Supreme Court, U.S.
FILED
MAY 8 - 2006
OFFICE OF THE CLERK

No. 05-1424

In The
Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY,

Petitioner,

v.

PEGGY HAWKINS-DEAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

GENE C. SCHAERR
WINSTON & STRAWN LLP
1700 K Street, N.W.
Washington, D.C. 20006
(202) 282-5000

LINDA T. COBERLY
WINSTON & STRAWN LLP
35 West Wacker Drive
Chicago, Illinois 60601
(312) 558-5600

AMY K. POSNER
METROPOLITAN LIFE INSURANCE COMPANY
27-01 Queens Plaza North
Long Island City, New York 11101
(212) 578-8296

LEE T. PATERSON
Counsel of Record
AMANDA SOMMERFELD
WINSTON & STRAWN LLP
333 South Grand Avenue
Los Angeles, California 90071
(213) 615-1700

Counsel for Petitioner

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Whether the Ninth Circuit erred in reviewing *de novo*, in conflict with decisions in nine other Circuits, a benefit decision by an administrator of an ERISA-regulated plan that grants the administrator discretion in making benefit decisions?

2. Whether the Ninth Circuit erred in holding, in conflict with decisions in the First, Second, Fourth, Fifth, Seventh and Tenth Circuits that when a plan participant provides evidence tending to show a conflict of interest on the part of an administrator of an ERISA-regulated plan, the administrator, not the participant, bears the burden of proof as to whether a conflict of interest tainted the administrator's benefits decision.

3. Whether the Ninth Circuit erred in entering judgment awarding a disabled employee monthly benefits that far exceed her pre-disability earnings by including profits she realized from the sale of company stock shortly before she filed her claim.

PARTIES TO THE PROCEEDINGS

The parties to the proceedings at the Ninth Circuit are the Petitioner-Defendant, Metropolitan Life Insurance Company, and the Respondent-Plaintiff, Peggy Hawkins-Dean. No judgment was entered by the district court against the employer, Robert Half International, and it was not a party to the appeal of the district court's judgment. There are no other parties.

RULE 29.6 STATEMENT

Petitioner, Metropolitan Life Insurance Company, is a wholly owned subsidiary of MetLife, Inc., which is a publicly traded company. No publicly held entity owns 10% or more of MetLife's stock.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
PARTIES TO THE PROCEEDINGS	ii
RULE 29.6 STATEMENT	ii
PETITION FOR A WRIT OF CERTIORARI	1
OPINION BELOW	1
JURISDICTION	1
STATUTES AND REGULATIONS INVOLVED	2
STATEMENT	2
REASONS FOR GRANTING THE PETITION	6
I. The Ninth Circuit's "Presumptively Void" Standard Of Review Warrants This Court's Review	7
A. The Ninth Circuit's Decision Squarely Conflicts With Decisions In Nine Other Circuits	9
B. The Ninth Circuit's Decision Is Contrary To This Court's Decision In *Firestone v. Bruch*	14
C. The Presumptively Void Rule Contravenes Congressional Purpose	16
D. The Court's Resolution Of This Issue Is Vital And This Case Is An Ideal Vehicle For Resolving It	17
II. The Ninth Circuit's Rule Shifting The Burden Of Proof Likewise Merits This Court's Review	21

TABLE OF CONTENTS – Continued

Page

A. The Ninth Circuit's Rule Shifting The Burden To The Claim Administrator Is In Direct Conflict With Decisions Of Six Other Circuits 22

B. The Ninth Circuit's Shift Of The Burden Of Proof To The Claim Administrator Conflicts With Common Law 23

C. The Ninth Circuit's Categorical Rule Contravenes Congressional Goals And Is Based Upon Unsupported Generalizations 24

CONCLUSION 29

TABLE OF AUTHORITIES

Page

CASES:

Abatie v. Alta Health & Life Insurance Co., 421 F.3d 1053 (9th Cir. 2005) 19

Alford v. DCH Foundation Group Long-Term Disability Plan, 311 F.3d 955 (9th Cir. 2002) 19

Ass'n of Data Processing Service Organizations, Inc. v. Board of Governors of Federal Reserve System, 745 F.2d 677 (D.C. Cir. 1984) 10

Atwood v. Newmont Gold Co., 45 F.3d 1317 (9th Cir. 1995) ..... *passim*

Bendixen v. Standard Insurance Co., 185 F.3d 939 (9th Cir. 1999) 18

Bergt v. Retirement Plan for Pilots Employed by Mark Air, Inc., 293 F.3d 1139 (9th Cir. 2002) 19

Block v. Pitney Bowes, Inc., 952 F.2d 1450 (D.C. Cir. 1992) 10, 11

Booth v. Wal-Mart Stores Inc., 201 F.3d 335 (4th Cir. 2000) 11

Boyd v. Bell, 410 F.3d 1173 (9th Cir. 2005) 19

Brown v. Blue Cross & Blue Shield, Inc., 898 F.2d 1566 (11th Cir. 1990) 8, 13

Brown v. Blue Cross & Blue Shield of Alabama, Inc., 898 F.2d 1556 (11th Cir. 1990) 17

Chalmers v. Quaker Oats Co., 61 F.3d 1340 (7th Cir. 1995) 26

Chambers v. Family Health Plan Corp., 100 F.3d 818 (10th Cir. 1996) 20

TABLE OF AUTHORITIES – Continued

Page

Colucci v. Agfa Corp. Severance Pay Plan, 431 F.3d 170 (4th Cir. 2005) 22

Cozzie v. Metropolitan Life Insurance Co., 140 F.3d 1104 (7th Cir. 1998) 26

Cuddington v. Northern Ind. Public Serv. Co., 33 F.3d 813 (7th Cir. 1994) 26

Doe v. Travelers Insurance Co., 167 F.3d 53 (1st Cir. 1999) 10, 17

Egelhoff v. Egelhoff, 532 U.S. 141 (2001) 17, 18

Ellis v. Liberty Life Assur. Co., 394 F.3d 262 (5th Cir. 2004) 22

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) ..... *passim*

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987) 24

Fought v. UNUM Life Insurance Co. of America, 379 F.3d 997 (10th Cir. 2004), *cert. denied*, 125 S. Ct. 1972 (2005) 12, 16, 22

Friedrich v. Intel Corp., 181 F.3d 1105 (9th Cir. 1999) 5, 8, 18

Gatti v. Reliance Standard Life Insurance Co., 415 F.3d 978 (9th Cir. 2005) 19

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990) 18

Jordan v. Northrop Grumman Corp. Welfare Benefit Plan, 370 F.3d 869 (9th Cir. 2004) 19

Kearney v. Standard Insurance Co., 175 F.3d 1084 (9th Cir. 1999) 18

TABLE OF AUTHORITIES – Continued

Page

Lang v. Long-Term Disability Plan, 125 F.3d 794 (9th Cir. 1997) 8, 18

Manny v. Cent. States, Southeast & Southwest Areas Pension & Health & Welfare Funds, 388 F.3d 241 (7th Cir. 2004) 12

McDaniel v. Chevron Corp., 203 F.3d 1099 (9th Cir. 2000) 18

Mers v. Marriott International Group Accidental Death & Dismemberment Plan, 144 F.3d 1014 (7th Cir. 1998) 20, 22

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995) 18

Nord v. Black & Decker Disability Plan, 296 F.3d 823 (9th Cir. 2002), *vacated by*, 538 U.S. 822 (2003) 19, 20

Pagan v. NYNEX Pension Plan, 52 F.3d 438 (2d Cir. 1995) 10, 14, 20

Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan, 195 F.3d 975 (7th Cir. 2000) 20, 25

Peruzzi v. Summa Medical Plan, 137 F.3d 431 (6th Cir. 1998) 11

Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987) 27

Pinto v. Reliance Standard Life Insurance Co., 214 F.3d 377 (3rd Cir. 2000) 12, 20

Ragsdale v. Wolverine World Wide, Inc., 535 U.S. 81 (2002) 25

TABLE OF AUTHORITIES – Continued

Page

Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130 (9th Cir. 2001) 19

Schaffer v. Weast, ___ U.S. ___, 126 S. Ct. 528 (2005) 23

Schikore v. BankAmerica Supplemental Retirement Plan, 269 F.3d 956 (9th Cir. 2001) 9, 19

Estate of Shockley v. Alyeska Pipeline Serv. Co., 130 F.3d 403 (9th Cir. 1997) 18

Snow v. Standard Insurance Co., 87 F.3d 327 (9th Cir. 1996) 18

Sullivan v. LTV Aero. & Defense Co., 82 F.3d 1251 (2d Cir. 1996) 23

Tremain v. Bell Industrial, 196 F.3d 970 (9th Cir. 1999) 8, 18

Varity Corp. v. Howe, 516 U.S. 489 (1996) 26, 27

Vega v. National Life Insurance Services, 188 F.3d 287 (5th Cir. 1999) 12

Wallace v. Reliance Standard Life Insurance Co., 318 F.3d 723 (7th Cir. 2003) 20

Woo v. Deluxe Corp., 144 F.3d 1157 (8th Cir. 1998) 11

Wright v. R. R. Donnelley & Sons Co. Group Benefits Plan, 402 F.3d 67 (1st Cir. 2005) 22

Zavora v. Paul Revere Life Insurance Co., 145 F.3d 1118 (9th Cir. 1998) 18

TABLE OF AUTHORITIES – Continued

Page

STATUTES AND RULES:

28 U.S.C. § 1254(1) 1

29 U.S.C.
§ 1001b(c)(5) 27
§ 1102(c) 2, 16
§ 1104(a)(1) 26
§ 1106 16
§ 1107 16
§ 1107(a) 2
§ 1108(c) 2
§ 1108(c)(3) 16
§ 1114 2
§ 1132(a) 4

OTHER SOURCES:

H. R. Rep. No. 533, 93d Cong., 2nd Sess. 1, reprinted in 1974 U.S.C.C.A.N. 4639 27

Issues in the Third Circuit Reconciling the ERISA Fiduciary's Dual Responsibilities: An Overview of the Inconsistency Among the Circuits Concerning the Conflict of Interest Analysis Applied in an ERISA Action with an Emphasis on the Eighth Circuit's Adoption of the Sliding Scale Analysis in *Woo v. Deluxe Corporation*, 75 North Dakota L.R. 815 (1999) 8

Kennedy, *Judicial Standard of Review in ERISA Benefit Decisions*, 50 American University L. Rev. 1083 (2001) 8

TABLE OF AUTHORITIES – Continued

Page

McCormick on Evidence § 337, at 412 23

C. Mueller & L. Kirkpatrick, *Evidence* § 3.1 (3d ed. 2003) 23

Restatement (Second) of Trusts § 187, Comment *d* (1959) 6, 8, 10, 11, 15

PETITION FOR A WRIT OF CERTIORARI

Petitioner, Metropolitan Life Insurance Company, respectfully petitions for a writ of certiorari to review the January 6, 2006 decision of the United States Court of Appeals for the Ninth Circuit, which, following prior Ninth Circuit precedent, placed the burden of proof on an ERISA claims administrator to prove that a conflict of interest did not affect its decision on a benefit amount, held that the administrator's decision should have been reviewed *de novo* and entered judgment against the administrator.

OPINION BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit reversing the decision of the United States District Court for the Central District of California is not reported and is reproduced in the Appendix. (App. 1) That decision, however, followed and applied the standard of review mandated by the Ninth Circuit's decision in *Atwood v. Newmont Gold Co.*, 45 F.3d 1317 (9th Cir. 1995). The opinion of the District Court is not reported and is reproduced in the Appendix. (App. 5)

JURISDICTION

The judgment of the Court of Appeals was entered on January 6, 2006 and the time for filing this petition was extended by Justice Ginsburg to May 8, 2006. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The Employee Retirement Income Security Act of 1974, as amended ("ERISA"), provides in pertinent part:

> Any employee benefit plan may provide – (1) that any person or group of persons may serve in more than one fiduciary capacity with respect to the plan (including service both as trustee and administrator).

29 U.S.C. § 1102(c).

> Except as otherwise provided in this section and section 1114 of this title:
>
> (1) A plan may not acquire or hold –
>
> (A) any employer security which is not a qualifying employer security, or
>
> (B) any employer real property which is not qualifying employer real property.

29 U.S.C. § 1107(a).

> Nothing in section 1106 of this title shall be construed to prohibit any fiduciary from – . . .
>
> (3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

29 U.S.C. § 1108(c).

STATEMENT

1. Respondent, Peggy Hawkins-Dean, claimed long-term disability benefits under an ERISA-regulated plan

provided by her employer, Robert Half International. She requested monthly disability benefits based on her 1998 wages of $28,850 and her 1998 receipts of $123,004.97 from stock sold just prior to applying for disability benefits. (SR 120-131[1]) She obtained the stock from stock options she was granted in prior years by her employer. (SR 123-140) The Summary Plan Description provides that her basic monthly benefit is 60% of the monthly average of "your earnings, including overtime and bonuses, for the prior calendar year as reported by the Employer on Wage Form W-2. . . . " (SR 9) Respondent's 1998 W-2 does not contain the word "earnings" but, as required by federal law, did include the amounts from the sale of stock obtained through the stock option plan. (R 132)

The disability plan vests discretion in the claims administrator, Metropolitan Life Insurance Company ("MetLife"), "to interpret the terms of the plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan." (SR 69)

Respondent claimed that she could no longer work as a result of fibromyalgia. (SR 75) Respondent's claim, which contained only documentation concerning subjective pain complaints, was denied due to a lack of objective medical findings and medical tests supporting the conclusion of total disability. (SR 97-98)

On November 19, 2001, Respondent appealed the denial of her claim by filing a Complaint in the United

---

[1] References to the Appellant's Excerpts of Record to the Ninth Circuit are preceded by an "R"; references to the Appellee's Supplemental Excerpts of Record to the Ninth Circuit are preceded by an "SR."

States District Court for the Central District of California, pursuant to 29 U.S.C. § 1132(a). The parties briefed cross-motions for summary judgment, at which time Petitioner informed the District Court that, in an effort to resolve the claim, it had agreed to place Respondent in "pay status" on her claim and pay any back benefits that were then due. (SR 153-155) The District Court granted Respondent's Motion for Summary Judgment on the issue of liability and denied her motion as to the calculation of benefits, instead granting Petitioner's Motion for Summary Judgment on that issue and agreeing with Petitioner that the calculation of benefits must be remanded to the Plan administrator. (*Id.*) In doing so, the District Court concluded that the Plan administrator was entitled to determine whether stock receipts constitute "Basic Monthly Earnings" under the terms of the Plan as argued by Respondent. (*Id.*)

Petitioner, relying upon information from the employer that it did not treat income from the sale of stock as earnings under any of the employer's benefit plans (SR 115-118, 141-144A), made a determination that income from the sale of company stock was not "earnings, including overtime and bonuses, for the prior Calendar Year" and did not include that amount in its determination of the monthly benefit amount. (SR 135-138)

Respondent again sought review from the District Court by initiating another lawsuit on February 18, 2003. At the conclusion of discovery, Petitioner and Respondent made cross-motions for summary judgment. On January 29, 2004, the District Court denied both motions and granted judgment on the record for Petitioner, finding that the administrator had not abused its discretion in determining the monthly benefit amount when it excluded

Respondent's 1998 receipts from the sale of her stock. (App. 5)

2. Respondent appealed the decision to the United States Court of Appeals for the Ninth Circuit. The Ninth Circuit Panel, without finding any clear error in the District Court's findings of fact, overruled the District Court's decision and ordered judgment for Respondent. (App. 1) In so doing, the Panel applied the Ninth Circuit's "presumptively void" standard of review to the administrator's benefits decision. *Atwood v. Newmont Gold Co.*, 45 F.3d 1317 (9th Cir. 1995). The Panel found the administrator, as the insuring entity, had an inherent conflict of interest and that its prior denial of benefits was material, probative evidence tending to show an actual conflict of interest. The Panel then held that the burden of proof shifted to the Petitioner to prove that a conflict did not affect its monthly benefit amount decision. (App. 1) The Petitioner relied upon evidence showing that the stock had been received in calendar years prior to 1998 (R 120-134) and that the company practice was to exclude receipts from the sale of stock in determining monthly disability benefits. (SR 115-118, 141-144A) However, the Panel, making no reference to the Petitioner's evidence, found that its decision was tainted by an actual conflict.[2] The Panel then reviewed the record *de novo* and, based on the doctrine of *contra proferentem*, found that the earnings for the prior calendar year included the receipts from the sale of stock. (App. 1) The effect of the Ninth Circuit's decision is that Respondent's base income for calculation of her

[2] The Panel failed to follow prior Ninth Circuit precedent that requires that the court review "underlying facts for clear error." *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1109 (9th Cir. 1999).

monthly disability benefit is inflated to $151,855 a year from $28,850 a year.

REASONS FOR GRANTING THE PETITION

The Ninth Circuit's decision is the latest manifestation of a mature, deep and acknowledged conflict between the Ninth and Eleventh Circuits and the other regional courts of appeal on two important questions in ERISA employee-benefits law. The first is whether a court may review *de novo* the benefit decision by an ERISA-regulated administrator, that has been granted discretion by the plan, where there is the appearance of a conflict of interest. On that issue, the Ninth and Eleventh Circuits hold that where an ERISA administrator has a conflict of interest, its decision is presumptively void and must be reviewed *de novo*. In direct conflict, the First, Second, Fourth, and Sixth Circuits hold that in the case of a conflict of interest, the claim administrator's decision must be reviewed under a deferential Restatement of Trusts § 187 "reasonableness" standard that considers the conflict as a factor to be weighed by the court; the Third, Fifth, Seventh, Eighth and Tenth Circuits hold that such a decision must be reviewed under a "sliding scale" approach that considers the severity of the conflict.

The second related issue is whether an ERISA administrator has the burden of proof to establish that its decision was not tainted by a conflict of interest. Here again, the regional courts of appeal are divided in an entrenched split of authority. The Ninth and Eleventh Circuits hold that if the plaintiff offers "material, probative evidence tending to show a conflict of interest," the

administrator has the burden of establishing that its decision was not tainted by a conflict of interest. In direct conflict with the Ninth and Eleventh Circuits, the First, Second, Fourth, Fifth, Seventh and Tenth Circuits hold that the party challenging the benefit decision has the burden of proving that the administrator's decision was affected by a conflict of interest.

On both of these issues, the Ninth Circuit's decision conflicts with this Court's decision in *Firestone v. Bruch,* 489 U.S. 101, 115 (1989). There, the Court held that the standard of review of an ERISA administrator's decision, where the administrator has been given discretion by the plan, is **always** for abuse of discretion and not *de novo.* The Court also said that an alleged conflict of interest is weighed as merely one of six factors in determining whether an administrator has abused its discretion and not as the only factor. The Ninth Circuit departed from these teachings both in applying a *de novo* standard and in imposing the burden of proof on the administrator to prove a negative, i.e., that its decision was not tainted by conflict.

Each of these issues demands this Court's resolution, and this case provides an excellent vehicle with which to do so.

I. The Ninth Circuit's "Presumptively Void" Standard Of Review Warrants This Court's Review.

In *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989), this Court stated,

> Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be

> weighed as a 'facto[r] in determining whether there is an abuse of discretion.' Restatement (Second) of Trusts § 187, Comment *d* (1959).

Interpreting this sentence, the Ninth and Eleventh Circuits have adopted the "presumptively void"[3] standard of review. In the Ninth Circuit, if a beneficiary of an ERISA plan provides "material, probative evidence" tending to show a conflict of interest, then the administrator "must rebut the presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits." If the administrator fails to prove a negative – i.e., that the conflict did **not** affect its decision – its decision is void and the court reviews the benefit determination *de novo*. *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995); *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1566, 1567 (11th Cir. 1990).

The Ninth Circuit, moreover, has held that "material, probative evidence tending to show a conflict" includes such things as: inconsistent reasons for denying benefits, *Lang v. Long-Term Disability Plan,* 125 F.3d 794, 799 (9th Cir. 1997); failure to follow internal procedures, *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1110 (9th Cir. 1999); inadvertent use of the wrong plan's disability definition, *Tremain v. Bell Indus.*, 196 F.3d 970, 977 (9th Cir. 1999); and refusal to

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[3] This is the name attached to this standard of review by commentators. *See Issues in the Third Circuit Reconciling the ERISA Fiduciary's Dual Responsibilities: An Overview of the Inconsistency Among the Circuits Concerning the Conflict of Interest Analysis Applied in an ERISA Action with an Emphasis on the Eighth Circuit's Adoption of the Sliding Scale Analysis* in *Woo v. Deluxe Corporation*, 75 North Dakota L.R. 815, 853 (1999); Kennedy, *Judicial Standard of Review in ERISA Benefit Decisions*, 50 American University L. Rev. 1083, 1158 (2001).

accept a claim based on the date it was received rather than on the date it was mailed. *Schikore v. BankAmerica Supplemental Ret. Plan*, 269 F.3d 956, 961 (9th Cir. 2001). In this case, despite its recognition that MetLife had discretionary authority and the fact that the District Court had remanded the benefit amount issue to MetLife for determination, the Ninth Circuit found "MetLife's denial and subsequent concession of eligibility for disability benefits was material, probative evidence tending to show that MetLife's decision regarding the amount of benefits due to Hawkins-Dean was affected by self-interest." (App. 1)

The Ninth Circuit's "presumptively void" rule applies equally to all plans where the administrator is connected to the funding source regardless of the type of plan, the administrator, or the method of funding. The Ninth Circuit's rationale for the rule is that, "[u]nder the common law of trusts, any action taken by a trustee in violation of a fiduciary obligation is presumptively void." *Atwood*, 45 F.3d at 1323.

As the Ninth Circuit acknowledged in *Atwood*, there is a conflict in the Circuits as to the appropriate standard of review. *Id.* Moreover, the Ninth Circuit's approach is contrary to Congress's understanding in enacting ERISA and to this Court's decision in *Firestone*. The issue demands definitive resolution by this Court.

A. The Ninth Circuit's Decision Squarely Conflicts With Decisions In Nine Other Circuits.

All of the Circuits state that where an ERISA fiduciary has discretionary authority, a reviewing court must apply either an arbitrary and capricious or an abuse of

discretion standard of review.[4] However, at that point the Circuits diverge. In general, where a conflict of interest has been alleged, there are at least three distinct and conflicting standards of review.

Restatement of Trusts § 187 Standard. Consistent with Section 187 of the Restatement, the First, Second, Fourth, and Sixth Circuits review the claim administrator's decision for reasonableness. In *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999), for example, the First Circuit declined to review an administrator's benefit decision *de novo* and held:

> The essential requirement of reasonableness has substantial bite itself where, as here, we are concerned with a specific treatment decision based on medical criteria and not some broad issue of public policy.

Similarly, the Second Circuit has held "the existence of such an alleged conflict does not operate to change the standard of review, but rather becomes 'a factor in determining whether there is an abuse of discretion,'" and "a reasonable interpretation of the Plan will stand unless the participants can show not only that a potential conflict of interest exists, . . . but that the 'conflict affected the reasonableness of the Committee's decision.'" *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 442-43 (2d Cir. 1995).

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[4] *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992) (Ginsburg, J.) ("The distinction, if any, between 'arbitrary and capricious review' and review for 'abuse of discretion' is subtle."); *Ass'n of Data Processing Service Organizations, Inc. v. Board of Governors of Federal Reserve System*, 745 F.2d 677, 684 (D.C. Cir. 1984) (Scalia, J.) (distinction between substantial evidence test and arbitrary or capricious test is "largely semantic").

The Fourth Circuit likewise holds that a conflict of interest is one of eight factors for evaluating the reasonableness of the administrator's decision and may reduce the deference afforded the administrator. *Booth v. Wal-Mart Stores Inc.*, 201 F.3d 335, 342-43, n.2 (4th Cir. 2000). And the Sixth Circuit holds that the conflict of interest inherent in self-funded plans does not alter the standard of review, but "should be taken into account as a factor in determining whether the decision was arbitrary and capricious." *Peruzzi v. Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998).[5]

If the Ninth Circuit had applied a Restatement § 187 reasonableness review, the Panel would have had to have concluded, as did the District Court, that the Petitioner's decision – i.e., that profits received from the sale of stock granted through a stock option plan in the five years before the prior calendar year were not "earnings from . . . the prior calendar year" – was reasonable.

The Sliding Scale Standard. The Third, Fifth, Seventh, Eighth and Tenth Circuits apply a more demanding "sliding scale" standard in which the reviewing court intensifies its scrutiny of the administrator's decision as the seriousness of the conflict increases. For example, in *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998), the Eighth Circuit held that "a reviewing court will always review for an abuse of discretion, but it will decrease the

[5] The D.C. Circuit has not ruled in a case where an administrator has an actual conflict of interest. The Circuit applies a Restatement § 187 standard of review to claim administrator benefit decisions where no actual conflict is alleged. *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450 (D.C. Cir. 1992).

deference given to the administrator in proportion to the seriousness of the conflict of interest or procedural irregularity."

Similarly, in *Vega v. National Life Ins. Servs.*, 188 F.3d 287, 297 (5th Cir. 1999), the Fifth Circuit considered *en banc* the standard of review of ERISA administrator's decisions and reaffirmed its adherence to the sliding scale standard: "The greater the evidence of conflict on the part of the administrator, the less deferential our abuse of discretion standard will be."

The Seventh Circuit likewise approved the sliding scale approach in *Manny v. Cent. States, Southeast & Southwest Areas Pension & Health & Welfare Funds*, 388 F.3d 241, 243 (7th Cir. 2004) ("It is 'a sliding scale' that requires that judicial review be 'more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is.'"). And similarly, in *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004), *cert. denied*, 125 S. Ct. 1972 (2005), the Tenth Circuit approved a sliding scale standard of review stating, "When the plan administrator operates under either (1) an inherent conflict of interest, between its discretion in paying claims and its need to stay financially sound; (2) a proven conflict of interest; or (3) when a serious procedural irregularity exists, and the plan administrator has denied coverage, an additional reduction in deference is appropriate." The Third Circuit also follows the sliding scale approach. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3rd Cir. 2000) ("We adopt the approach of the sliding scale cases.").

If the Ninth Circuit Panel in this case had used a sliding scale approach, it could not have negated the

administrator's discretion and made its own *de novo* decision, but instead would have had to have balanced the administrator's discretion against the degree of conflict. Given that the alleged evidence of conflict was only a change in benefit eligibility and that the administrator's interpretation of the phrase "earnings, including overtime and bonuses, for the prior Calendar Year" was based on a consistent past practice, the Panel would almost certainly have sustained the District Court's decision.

The Presumptively Void Standard. As explained above, in the Ninth and Eleventh Circuits, if a plaintiff alleges that a claim administrator has a conflict of interest and provides "material, probative evidence tending to show a conflict," the administrator's decision is presumptively void. Unless the administrator can overcome the presumption, the court will consider its decision void, grant it no deference and review *de novo*. Even where the court finds the administrator's decision is reasonable, the Ninth and Eleventh Circuits will still review *de novo*.[6]

In this case, the administrator presented evidence that the stock options were received prior to the Plan calculation period, that the employer always excluded receipts from the sale of stock in its calculation of "earnings" under the Plan, and that the administrator's decision was prudently preserving the assets of the Plan for all beneficiaries by fairly calculating benefits based on actual earnings for the prior year, as opposed to granting

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[6] *See Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1322 (9th Cir. 1995), citing and adopting the Eleventh Circuit's holding in *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1566, 1567 (11th Cir. 1990), that "a wrong but apparently reasonable interpretation is arbitrary and capricious."

windfalls to beneficiaries who go out on total disability shortly after they cash in company stock. Such evidence was apparently ignored by the Ninth Circuit.

B. The Ninth Circuit's Decision Is Contrary To This Court's Decision In *Firestone v. Bruch.*

The Ninth Circuit's presumptively void standard of review permits *de novo* court review of an administrator's benefit decision even where the plan grants discretion to the administrator. Such *de novo* review directly contravenes this Court's decision in *Firestone v. Bruch*, in two respects.

First, the Ninth Circuit's application of *de novo* review contravenes the clear instruction in *Bruch* that the decision of an administrator in whom a plan vests discretion must be reviewed for abuse of discretion. As stated by the Second Circuit in a similar case,

> *Bruch* instructs us, however, that the existence of such an alleged conflict does not operate to change the standard of review, but rather becomes "a factor in determining whether there is an abuse of discretion."

Pagan v. NYNEX Pension Plan, 52 F.3d 438, 442 (2d Cir. 1995).

The Ninth Circuit, in this case as well as others, has used conflict of interest as a test to determine whether to apply an abuse of discretion standard or a *de novo* standard of review. But under *Firestone,* a conflict of interest has no bearing on whether *de novo* review will occur, where, as here, the plan grants the administrator

discretion. If the plan grants discretion, then even a conflicted administrator has discretion. The question is the extent, if any, to which the discretion has been abused.

Second, the Ninth Circuit's decision departs from *Firestone*'s teaching that whether an abuse of discretion has occurred must be determined on the basis of several factors, not just one. *Firestone* referenced the six factors listed in the Restatement (Second) of Trusts § 187, Comment *d* (1959):

> (1) the extent of the discretion conferred upon the trustee by the terms of the trust;
>
> (2) the purposes of the trust;
>
> (3) the nature of the power;
>
> (4) the existence or non-existence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged;
>
> (5) the motives of the trustee in exercising the power;
>
> (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.

The Ninth Circuit's approach, by contrast, neither weighs nor considers the first five *Firestone* factors. In applying the presumptively void test here, the only consideration by the Panel was (1) whether the beneficiary had offered material, probative evidence tending to show a conflict and (2) whether the administrator proved that a conflict did not taint its decision. Thus, in this case, the court only considered one factor – conflict – and did not weigh it or compare it to any of the other five factors. Using conflict of

interest to change the standard of review from arbitrary and capricious to *de novo* elevates conflict from merely **one** factor to **the** determining factor. That approach cannot be reconciled with *Firestone*.

C. The Presumptively Void Rule Contravenes Congressional Purpose.

The Ninth Circuit's approach also contravenes Congressional purposes in enacting the statute. Congress was aware of the inherent conflict of interest of claim administrators who were also employers or insurers. Indeed, ERISA specifically provides that "[a]ny employee benefit plan may provide – (1) that any person or group of persons may serve in more than one fiduciary capacity with respect to the plan (including service both as trustee and administrator)." 29 U.S.C. § 1102(c). ERISA thus envisions that a fiduciary "may 'wear two hats,' one of a trustee or fiduciary and one settlor." *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1005 (10th Cir. 2004), *cert. denied*, 125 S. Ct. 1972 (2005).

Another provision, 29 U.S.C. § 1108(c)(3), implicitly authorizes an officer of the sponsor corporation to serve as a pension plan fiduciary by providing that 29 U.S.C. § 1106 (specifying prohibited transactions) shall not be construed so as "to prohibit any fiduciary . . . from serving as a fiduciary in addition to being an officer, employee agent, or other representative of a party in interest." Further, 29 U.S.C. § 1107 specifically authorizes a plan to acquire stock of the sponsoring corporation. ERISA therefore contemplates that trustees, who may be officers of the sponsoring company, may act on behalf of a plan in spite of traditional conflict of interest law.

In spite of Congress's intent, the presumptively void rule has been justified as a means to discourage employers from appointing their employees and their insurance companies as fiduciary administrators. As the Eleventh Circuit put it, "one reason for limiting the deference when the fiduciary suffers a conflict of interest is to discourage arrangements where a conflict arises." *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1564 (11th Cir. 1990). In other words, even though Congress specifically authorized employers and insurance companies to act as ERISA administrators, the presumptively void rule is designed to discourage them from doing so. The Court should grant review to bring the Ninth and Eleventh Circuit's interpretation of ERISA into line with Congress's purposes.

D. The Court's Resolution Of This Issue Is Vital And This Case Is An Ideal Vehicle For Resolving It.

This case provides an excellent opportunity for resolving the conflicts among the circuits about the appropriateness of a *de novo* standard of review of an ERISA administrator's benefit decisions.

First, it will enable the Court to achieve one of ERISA's "principal" goals which was to "establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001), quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). When it enacted ERISA, Congress intended

> [T]o ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656-657 (1995), quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

Despite this Congressional purpose, the Ninth and Eleventh Circuits apply a standard of review that conflicts directly with the standards of review used by other circuit courts. "Uniformity is impossible" if different circuits subject decisions by administrators to different legal obligations. *Egelhoff*, 532 U.S. at 148. Because of the split in the circuits, an administrator of a national benefit plan may have the same benefit decision accepted in one or more circuits and rejected by the Ninth Circuit, and will be thereby forced to administer claims according to different standards.

Second, the issues are clear and well developed and the conflict is extensive and mature. The Ninth Circuit has issued over 20 published opinions[7] and 35 unpublished

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[7] *Snow v. Standard Ins. Co.*, 87 F.3d 327, 330 (9th Cir. 1996); *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech.*, 125 F.3d 794 (9th Cir. 1997); *Estate of Shockley v. Alyeska Pipeline Serv. Co.*, 130 F.3d 403, 405 (9th Cir. 1997); *Zavora v. Paul Revere Life Ins. Co.*, 145 F.3d 1118, 1122 (9th Cir. 1998); *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1110 (9th Cir. 1999); *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1087 (9th Cir. 1999); *Bendixen v. Standard Ins. Co.*, 185 F.3d 939 (9th Cir. 1999); *Tremain v. Bell Indus.*, 196 F.3d 970 (9th Cir. 1999); *McDaniel v.*

(Continued on following page)

opinions applying its presumptively void standard of review since it decided *Atwood*.

It is not likely that the Circuit will overturn *Atwood* after citing it as precedent for 11 years in over 55 cases. Nor is it likely that the Circuits applying standards that conflict with the Ninth Circuit will have a change of mind and embrace the Ninth Circuit's position. In fact, those Circuits that have reviewed the presumptively void standard of review have specifically rejected it. *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 442 (2d Cir. 1995) (rejecting presumptively void standard from *Brown v. Blue Cross and Blue Shield of Ala.*, 898 F.2d 1556, 1561-68 (11th Cir. 1990)); *Pinto v. Reliance Std. Life Ins. Co.*, 214 F.3d 377, 391 (3d Cir. 2000) (rejecting the presumptively void rule stating, "The essence of the [presumptively void] approach is that the fiduciary should be accorded deference, but only when deciding between options which are all in the best interest of the beneficiary or beneficiaries."); *Vega v. National Life Ins. Servs.*, 188 F.3d 287, 298 (5th Cir. 1999) (rejecting the presumptively void rule stating, "A rule that permitted such a result would be at odds with

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Chevron Corp., 203 F.3d 1099 (9th Cir. 2000); *Schikore v. BankAmerica Supplemental Ret. Plan*, 269 F.3d 956, 961 (9th Cir. 2001); *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), *vacated by*, 539 U.S. 901 (2003); *Nord v. Black & Decker Disability Plan*, 296 F.3d 823 (9th Cir. 2002), *vacated by*, 538 U.S. 822 (2003); *Bergt v. Ret. Plan for Pilots Employed by Mark Air, Inc.*, 293 F.3d 1139, 1142 (9th Cir. 2002); *Alford v. DCH Found. Group Long-Term Disability Plan*, 311 F.3d 955 (9th Cir. 2002); *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 370 F.3d 869, 877 (9th Cir. 2004); *Gatti v. Reliance Std. Life Ins. Co.*, 415 F.3d 978, 985 (9th Cir. 2005); *Boyd v. Bell*, 410 F.3d 1173, 1179 (9th Cir. 2005); *Abatie v. Alta Health & Life Ins. Co.*, 421 F.3d 1053, 1060 (9th Cir. 2005), *rehearing en banc granted, vacated by* 437 F.3d 860 (2006).

the Supreme Court's instruction in *Bruch* to review such determinations under an abuse of discretion standard – a standard that demands some deference be given to the administrator's decision."); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998) ("While some courts have found that a denial of benefits is presumptively void and must be reviewed *de novo* where a similar conflict may exist, . . . we have not"); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826 (10th Cir. 1996) ("We reject the 'presumptively void' test as inconsistent with our holding in *Pitman* and the Supreme Court's dictum in *Firestone*.").

Third, the lower courts have expressed a desire for further guidance in interpreting *Firestone*. For example, as stated in *Pinto v. Reliance Std. Life Ins. Co.*, 214 F.3d 377, 383 (3d Cir. 2000), "[s]ince *Firestone*, courts have struggled to give effect to this delphic statement, and to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." As stated by the Seventh Circuit, "Judges understand deferential and non-deferential review, but intermediate variations blur into one another without promoting understanding or consistent adjudication." *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981 (7th Cir. 1999). The Second Circuit echoed this concern when it expressed the hope that "[p]erhaps the Supreme Court will have an opportunity to reconsider this issue." *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 442 (2d Cir. 1995). *See also*, e.g., *Wallace v. Reliance Std. Life Ins. Co.*, 318 F.3d 723, 724 (7th Cir. 2003) (expressing expectation that the Court would resolve this issue in *Nord v. Black & Decker Disability Plan*, 538 U.S. 822 (2003)).

Given the conflict among the circuits, the desire for further guidance, and the vast amount of time being spent on these issues by the circuit and district courts, there is no reason to let this issue remain unresolved any longer.

II. The Ninth Circuit's Rule Shifting The Burden Of Proof Likewise Merits This Court's Review.

This case also presents a second, related issue that independently warrants review. In the Ninth Circuit, once a beneficiary offers evidence "tending to show" a conflict, the burden of proof shifts to the administrator to prove that its decision was not tainted. *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995). The administrator can attempt to prove that its decision was not affected by the conflict or that it was based on information by a reliable source or that it has made the same decision in all previous cases or that the decision was in the best interest of all of the plan participants even though it was detrimental to the participant. However, even that may not be enough. In this case, there was evidence that Respondent had received the stock in years prior to the relevant year (R 120-134), that the company never included receipts from the sale of stock in its monthly benefit calculation (SR 115-118, 141-141A), and that such a calculation would increase the income of the Plaintiff **significantly** compared to pre-disability earnings. Yet, the Panel still found that an actual conflict existed, reviewed *de novo*, and found the Petitioner's decision to be wrong. As shown below, the Ninth Circuit's burden-shifting approach conflicts with the rules applied in other circuits as well as with Congress's purposes and this Court's prior decisions. And here again, the issue demands this Court's review.

A. The Ninth Circuit's Rule Shifting The Burden To The Claim Administrator Is In Direct Conflict With Decisions Of Six Other Circuits.

Only the Ninth and Eleventh Circuits place the burden of proof on the administrator to show that its decision was not tainted by conflict. The Second Circuit has expressly rejected the burden shifting approach applied by the Ninth Circuit in *Atwood*, and the Eleventh Circuit in *Brown. Sullivan v. LTV Aero. & Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996). The First, Fourth, Fifth and Seventh Circuits have come to the same conclusion. *See*, e.g., *Wright v. R. R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74 n.4 (1st Cir. 2005) (The burden is on the claimant to demonstrate a conflict of interest.); *Colucci v. Agfa Corp. Severance Pay Plan*, 431 F.3d 170, 179-80 (4th Cir. 2005) (where a corporation also collaterally manages the plan, the plaintiff must prove that the administrator acted unreasonably and that the conflict of interest affected the benefits decision); *Ellis v. Liberty Life Assur. Co.*, 394 F.3d 262, 270 (5th Cir. 2004) ("an ERISA plaintiff must come forward with evidence that a conflict exists . . . and that any reduction in the degree of our deference depends on such evidence"); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998) (Claimant has burden to show "by providing specific evidence of actual bias that there is a significant conflict.").

The Tenth Circuit in *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004), *cert. denied*, 125 S. Ct. 1972 (2005), has recently adopted a hybrid in which the burden of proof on reasonableness of its decision is on the fiduciary, but the burden of proof with regard to the

conflict of interest remains with the participant. Thus, the conflict between the Ninth Circuit and other Circuits on this issue is also wide, deep, and mature.

B. The Ninth Circuit's Shift Of The Burden Of Proof To The Claim Administrator Conflicts With Common Law.

The Ninth Circuit's approach is also contrary to the common law of evidence. "The burdens of pleading and proof with regard to most facts have and should be assigned to the plaintiff who generally seeks to change the present state of affairs and who therefore naturally should be expected to bear the risk of failure or proof or persuasion." *McCormick on Evidence* § 337, at 412. As one commentator put it, "perhaps the broadest and most accepted idea is that the person who seeks court action should justify the request, which means that the plaintiffs bear the burdens on the elements in their claims." C. Mueller & L. Kirkpatrick, *Evidence* § 3.1, p. 104 (3d ed. 2003). Accordingly, as the Second Circuit explained in *Sullivan v. LTV Aero. & Defense Co.*, 82 F.3d 1251 (2d Cir. 1996), the Ninth Circuit's burden-shifting approach "is contrary to the traditional burden of proof in a civil case."

This Court reviewed this same issue in the recent case of *Schaffer v. Weast*, ___ U.S. ___, 126 S. Ct. 528, 534-35 (2005). In that case, the Court considered whether the parents or the school district bore the burden of persuasion (burden of proof) at a hearing on an individual education program for a learning disabled child. The Court found that while the underlying statute required a hearing, it did not state which party had the burden of proof. In the absence of statutory language, this Court said that

it should "begin with the ordinary default rule that plaintiffs bear the risk of failing to prove their claims." The Court reviewed other federal statutes which are silent on the burden of proof, including Title VII of the Civil Rights Act, the Americans with Disabilities Act, the Securities Exchange Act and the Endangered Species Act, and found that it had required or assumed in each of those cases that the plaintiff had the burden of proof. The Court concluded that "[a]bsent some reason to believe that Congress intended otherwise, therefore, we will conclude that the burden of persuasion lies where it usually falls, upon the party seeking relief." *Id.*

There is no statutory provision in ERISA regarding which party bears the burden of proof of a conflict of interest. In the absence of any Congressional action to place the burden of proof on the claim administrator, the common law rule should be the default here as well.

C. The Ninth Circuit's Categorical Rule Contravenes Congressional Goals And Is Based Upon Unsupported Generalizations.

The Ninth Circuit's burden-shifting regime also contravenes Congress's goals in enacting ERISA. One of the statute's principal goals is to enable employers "to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Yet given the existing conflict in the circuits, in the Ninth and Eleventh Circuit claim administrators must bear the burden of proving that they are not conflicted while in the rest of the nation the burden remains with the plaintiff.

Administrators also face the reality that in the Ninth Circuit any change in position, any modification of benefit entitlement or benefit amount will shift the burden of proof to them to prove that their entire benefit determination was not tainted by conflict. *See supra* at 7-8. For both of these reasons, the Ninth Circuit's burden-shifting scheme means that benefit decisions that would have been approved in other circuits will be overturned by the Ninth Circuit.

In addition, the Ninth Circuit's burden-shifting rule is a categorical rule that is based upon unsupported generalizations. In *Ragsdale v. Wolverine World Wide, Inc.*, 535 U.S. 81, 93 (2002), this Court said where "generalizations fail to hold in the run of cases . . . the justification for the categorical rule disappears." Here, there is no rational basis for a categorical rule that shifts the burden to the ERISA-regulated administrator to prove a negative – that its decision was not affected by a conflict. To the contrary, the Ninth Circuit's rule stereotypes insurance company administrators by assuming that they will inevitably place their own interests over the interests of the beneficiary. In many cases, an insurance company administrator may not have any self-interest. As the Seventh Circuit noted, an insurance company administrator "may not have any stake in the decision. . . . For many large firms, health and disability insurance on their labor forces is retrospectively rated. This means that the employer agrees to reimburse the insurer for all outlays, plus a loading charge and administration fee. We have no reason to think that [the company's] benefits staff is any more 'partial' against applicants than are federal judges when deciding income-tax cases." *Perlman v. Swiss Bank Corp. Comprehensive*

Disability Protection Plan, 195 F.3d 975, 981 (7th Cir. 2000).

A number of courts have rejected the categorical generalization that insurance company administrators will act in their own self-interest in making benefit decisions.

> Although MetLife acts as both administrator and insurer of the plan, that factor, standing alone, does not constitute a conflict of interest. *See Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995). Indeed, it has not been demonstrated that MetLife has a direct stake, in terms of its own financial health, in the outcome of this issue of interpretation. *See Cuddington v. Northern Ind. Pub. Serv. Co.*, 33 F.3d 813, 816 (7th Cir. 1994) (refusing to find a conflict on a similar theory absent "specific evidence showing that the [claim administrator] had a conflict of interest").

Cozzie v. Metropolitan Life Ins. Co., 140 F.3d 1104, 1108 (7th Cir. 1998).

Moreover, courts have recognized that a fiduciary, such as Petitioner, owes a duty not just to the participant who is seeking benefits, but also to the Plan as a whole. *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996); 29 U.S.C. § 1104(a)(1)(A). Plan fiduciaries cannot pay all claims regardless of merit, because if they do, premiums or contributions will have to rise – increasing costs to all participants. This principle is particularly applicable here, where Plaintiff seeks to increase her disability benefits five-fold based on her sale of stock obtained in prior years through the stock option plan. In this case, disability benefits were provided by the employer and underwritten by the insurer based on annual compensation provided and controlled by the employer. The Ninth Circuit's

decision permits the employee to control the amount of her own monthly disability benefit through her sale of stock in her stock option plan. No benefit plan, whether self funded or fully insured, could be reliably underwritten to plan for disability benefits where the employee controls the monthly benefit amount.

There is nothing in ERISA that justifies placing the burden of proof on an administrator to prove that its decision was not affected by a conflict of interest. ERISA was passed not only to protect the rights of beneficiaries but also to encourage employers to create and maintain voluntary benefit plans, *see* H. R. Rep. No. 533, 93d Cong., 2nd Sess. 1, reprinted in 1974 U.S.C.C.A.N. 4639, 4639, *Varity Corp. v. Howe*, 516 U.S. 489 (1996), and "to maintain the premium costs of [the ERISA] system at a reasonable level." 29 U.S.C. § 1001b(c)(5). This Court has emphasized both "the public interest in encouraging the formation of employee benefit plans" and "the need for prompt and fair claims settlement procedures." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). In *Varity Corp.*, 516 U.S. at 497, the Court pointed out that courts should take into account Congress's "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans." Requiring a claim administrator to prove that its benefit decisions was not tainted by conflict in every case where it changes its decision, makes an administrative error, or is just mistaken encourages litigation, increases plan costs, and may decrease the benefits available to other plan participants. It also discourages employers from establishing plans. And as noted, requiring companies to take into account windfall income from the exercise of stock options discourages the

formation of such plans because the vagaries of the stock market are impossible to predict, as is the cumulative value of years of stock options.

Finally, the Ninth Circuit's approach discourages administrators from reviewing their decisions and correcting mistakes when they find them. As noted, under the Ninth Circuit's burden-shifting approach, any change of mind or error in Plan administration puts the administrator at risk of proving that its decisions were not affected by a conflict of interest. In this case, for example, the administrator reviewed its benefit eligibility decision and reversed its prior finding that the beneficiary was not entitled to any benefits before the district court had ruled on the issue. (SR 135-138, 141-144A) In other words, the administrator decided to pay benefits without the need for a court ruling, yet the Ninth Circuit found that change in decision, by itself, was material, probative evidence tending to show a conflict of interest and on that basis alone placed the burden of proof on the administrator to show that its decision was not tainted. (App. 1) Rather than encouraging administrators to review decisions, the Ninth Circuit's approach discourages ERISA administrators from correcting honest mistakes and reviewing their prior decisions.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

GENE C. SCHAERR
WINSTON & STRAWN LLP
1700 K Street, N.W.
Washington, D.C. 20006
(202) 282-5000

LINDA T. COBERLY
WINSTON & STRAWN LLP
35 West Wacker Drive
Chicago, Illinois 60601
(312) 558-5600

AMY K. POSNER
METROPOLITAN LIFE
INSURANCE COMPANY
27-01 Queens Plaza North
Long Island City,
New York 11101
(212) 578-8296

LEE T. PATERSON
Counsel of Record
AMANDA SOMMERFELD
WINSTON & STRAWN LLP
333 South Grand Avenue
Los Angeles, California 90071
(213) 615-1700

Counsel for Petitioner

APPENDIX TABLE OF CONTENTS

Page

A Memorandum Opinion of the United States Court of Appeals for the Ninth Circuit (January 6, 2006).....App. 1

B Judgment in the United States Court of Appeals for the Ninth Circuit (January 6, 2006).....App. 4

C Order of the United States District Court, Central District of California, Case No. CV 03-1115 ER (January 28, 2004).....App. 5

APPENDIX A

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

PEGGY HAWKINS-DEAN, Plaintiff-Appellee, vs. METROPOLITAN LIFE INSURANCE COMPANY, a Corporation Defendant-Appellants. and ROBERT HALF INTERNATIONAL, INC., an ERISA Plan Defendant	No. 04-55277 D.C. No. CV-03-01115-ER MEMORANDUM* (Filed Jan. 6, 2006)

Appeal from the United States District Court
for the Central District of California,
Edward Rafeedie, District Judge, Presiding

Argued and Submitted November 15, 2005
Pasadena, California

Before: WARDLAW and PAEZ, Circuit Judges, and SINGLETON, District Judge.**

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* This disposition is not appropriate for publication and may not be cited except as may be provided by Ninth Circuit Rule 36-3.

** The Honorable James K. Singleton, Senior District Judge for the District of Alaska, sitting by designation.

Appellant Peggy Hawkins-Dean was employed by Robert Half International ("RHI") and was enrolled in RHI's Long-Term Disability Benefits Plan ("the Plan"). The Plan is funded by a group policy issued by Metropolitan Life Insurance Company ("MetLife") to RHI and is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* This matter was originally before the district court in a separate action regarding Hawkins-Dean's entitlement to long-term disability benefits under the Plan. MetLife denied Hawkins-Dean's benefits claim, and she brought suit. Before the district court ruled on the parties' motions for summary judgment, MetLife admitted Hawkins-Dean's benefits eligibility, leaving only the amount of benefits in question. The district court remanded the matter to MetLife to determine the amount of monthly benefits due to Hawkins-Dean. MetLife calculated the amount of benefits as 60% of Hawkins-Dean's earnings, not including stock options she received from RHI. This resulted in an amount significantly lower than Hawkins-Dean anticipated, and she again filed suit.

Faced with this controversy, the district judge held that MetLife, as the Plan administrator, did not abuse its discretion in calculating Hawkins-Dean's monthly benefit amount. The district judge correctly determined that under the terms of the Plan, MetLife, as the Plan administrator, had discretion to make disability and benefit determinations. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). We conclude, however, that MetLife's denial and subsequent concession of eligibility for disability benefits was material, probative evidence tending to show that MetLife's decision regarding the amount of benefits due to Hawkins-Dean was affected by

self-interest. *See Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1322-23 (9th Cir. 1995). Because MetLife did not demonstrate that the benefits amount decision was made in furtherance of its fiduciary duties, the district court should have reviewed the benefits amount determination de novo.

Ordinarily this conclusion would require remand to allow the district court to consider the evidence under the appropriate standard of review. Based on the record in this case and the doctrine of *contra proferentem*, however, we conclude that Hawkins-Dean is entitled to monthly benefits based on her total earnings, including earnings from stock options, as reported on her W-2 form. Remand, therefore, will be for an award of benefits consistent with this disposition.

REVERSED and REMANDED.

APPENDIX B

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

PEGGY HAWKINS-DEAN, Plaintiff-Appellant, v. METROPOLITAN LIFE INSURANCE COMPANY, a Corporation Defendant-Appellee, and ROBERT HALF INTERNATIONAL, INC., an ERISA Plan, Defendant.	No. 04-55277 D.C. No. CV-03-01115-ER **JUDGMENT**

Appeal from the United States District Court for the Central District of California, Los Angeles.

This cause came on to be heard on the Transcript of the Record from the United States District Court for the Central District of California, Los Angeles and was duly submitted.

On consideration whereof, it is now here ordered and adjudged by this Court, that the judgment of the said District Court in this cause be, and hereby is **REVERSED, REMANDED.**

Filed and entered 01/06/06

APPENDIX C

UNITED STATES DISTRICT COURT

CENTRAL, DISTRICT OF CALIFORNIA

PEGGY HAWKINS-DEAN Plaintiff, v. **METROPOLITAN LIFE INS. CO. AND ROBERT HALF INTERNATIONAL, INC.** Defendant.	Case No. CV03-1115-ER (VBKx) **ORDER DENYING CROSS MOTIONS FOR SUMMARY JUDGMENT AND GRANTING JUDGMENT ON THE ADMINISTRATIVE RECORD TO DEFENDANT METROPOLITAN LIFE INSURANCE COMPANY** **(FILED 11/17/03 AND 12/29/03)**

Having read and considered the papers filed in connection with the parties' cross motions for summary judgment and cross motions for judgment on the administrative record. The Court also heard oral argument on January 26, 2004, the Court has come to the following **CONCLUSIONS:**

[1] The Court begins by noting that the arguments raised by the Plaintiff at the January 26, 2004 hearing regarding whether the stock options reported on the Plaintiff's 1998 IRS Form W-2 were profits from options exercised in 1998 or were the reported valuation of options granted in that year were not raised in the Plaintiff's memoranda of law related to this motion and cannot be found anywhere in the long and exhaustive administrative record of this dispute. In any event, the argument is

irrelevant to the issue whether the Defendant committed an abuse of discretion in its determination of the amount of disability benefits due to the Plaintiff. Thus, for the reasons stated on the record, in open court, on January 26, 2004, the Court DENIES the cross motions for summary judgment, and the Court GRANTS Defendant MetLife's motion for judgment on the administrative record.

IT IS SO ORDERED.

IT IS FURTHER ORDERED that the Clerk of the Court shall serve, by United States mail or by telefax or by email, copies of this Order on counsel in this matter.

Dated: JAN 27, 2004

/s/ Edward Rafeedie
EDWARD RAFEEDIE
Senior United States
District Judge

FILE DATE
Oct 13 2006

No. 05-1424

In The

Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY,

Petitioner,

v.

PEGGY HAWKINS-DEAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

CHARLES J. FLEISHMAN
8383 Wilshire Blvd., Suite 1030
Beverly Hills, CA 90211
(323) 653-9772

Counsel for Respondent

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTION PRESENTED

Whether this Court should grant review where the claimed circuit split between the Ninth and other circuits – concerning the judicial standard of review where an ERISA plan claim fiduciary acts under a conflict of interest – has been recently harmonized with other circuits' standards by the *en banc* Ninth Circuit and, in any event, resolution of the standard of review issue would not affect the outcome in this case.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iii
INTRODUCTION	1
STATEMENT	2
REASONS FOR DENYING THE PETITION	4
A. The Ninth Circuit Has Overruled *Atwood*, Which Was the Decision on Which the Court Below Relied	4
B. The Circuits State the *Firestone* Rule in Slightly Different Ways, But That Does Not Amount to A Conflict, Much Less An Important One	6
C. Regardless of the Standard of Review, the Court Below Reached the Correct Result	9
CONCLUSION	12

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Atwood v. Newmont Gold, 45 F.3d 1317 (9th Cir. 1996) 1, 4, 5, 6, 10

Abatie Health & Life Ins. Co., 458 F.3d 955 (9th Cir. 2006) (en banc) ..... *passim*

Borda v. Hardy, Lewis, Pollard & Page, P.C., 138 F.3d 1062 (6th Cir. 1998) 6, 7

Brown v. Blue Cross & Blue Shield, Inc., 898 F.2d 1556 (11th Cir. 1990), cert. denied, 498 U.S. 1040 (1991) 1, 8

Buckley v. Metro. Life, 115 F.3d 936 (11th Cir. 1997) 8

Chojnacki v. Georgia-Pacific Corp., 108 F.3d 810 (7th Cir. 1997) 6

Clapp v. Citibank N.A. Disability Plan, 262 F.3d 820 (8th Cir. 2001) 7

Colucci v. AGFA Corp. Severance Pay Plan, 431 F.3d 170 (4th Cir. 2005), cert. denied, 126 S.Ct. 2300 (2006) 1

Delta Family-Care Disability & Survivorship Plan v. Marshall, 258 F.3d 834 (8th Cir. 2001), cert. denied, 534 U.S. 1162 (2002) 1

Doe v. Travelers Ins. Co., 167 F.3d 53 (1st Cir. 1999) 8

Ellis v. Metro. Life Ins. Co., 126 F.3d 228 (4th Cir. 1997) 6, 7

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) 4, 5, 6

TABLE OF AUTHORITIES – Continued

Page

Fought v. Unum Life Ins. Co. of Am., 379 F.3d 997 (10th Cir. 2004), cert. denied, 544 U.S. 1026 (2005) 1, 7

Greene v. Safeway, 210 F.3d 1237 (10th Cir. 2000) 11

HCA Health Services of Georgia, Inc. v. Employers Health Ins. Co., 240 F.3d 982 (11th Cir. 2001) 8

In re Burlington Coat Factory Sec. Lit., 114 F.3d 1410 (3d Cir. 1997) 11

Janeiro v. Urological Surgery Professional Ass'n, 457 F.3d 130 (1st Cir 2006) 7

Kobs v. United Wis. Ins. Co., 400 F.3d 1036 (7th Cir.), cert. denied, 126 S.Ct. 749 (2005) 1

Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014 (7th Cir.), cert. denied, 525 U.S. 947 (1998) 1

Pegram v. Herdrich, 530 U.S. 211 (2000) 5

Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377 (3d Cir. 2000) 6

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) 5

Scully v. U.S. WATS, Inc., 238 F.3d 497 (3d Cir. 2001) 11

Sullivan v. LTV Aerospace and Defense Co., 82 F.3d 1251 (2d Cir. 1996) 8

Torres v. Pittston Co., 346 F.3d 1324 (11th Cir. 2003) 8

TABLE OF AUTHORITIES – Continued

Page

United States v. Johnston, 268 U.S. 220 (1925) 9

Vega v. National Life Ins. Servs., 188 F.3d 287 (5th Cir. 1999) (en banc) 6

OTHER AUTHORITIES

MERRIAM WEBSTER'S COLLEGIATE DICTIONARY (10th Ed. 1997) 11

Restatement (Second) of Trusts § 170 5

Restatement (Second) of Trusts § 187(a) 5

R. Stern & E. Gressman, SUPREME COURT PRACTICE (8th ed. 2002) 4

Sup. Ct. R. 10 9

INTRODUCTION

Petitioner asks this Court to review an unpublished decision that is based on the Ninth Circuit's 1996 decision in *Atwood v. Newmont Gold*, 45 F.3d 1317 (9th Cir. 1996) ("*Atwood*"), *overruled by Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 966 (9th Cir. 2006) (en banc) ("*Abatie*"). Pet. for Cert., App. 1-3.[1] However, the en banc Ninth Circuit has recently overruled *Atwood*, thus rendering the reasoning of the decision below obsolete. *See Abatie*, 458 F.3d at 966. Any remaining variations among the circuits of the issue presented – the judicial standard of review where an ERISA plan claim fiduciary acts under a conflict of interest – do not amount to a genuine conflict among the circuits, much less an important one. On the contrary, the differences in the circuits' standard of review formulae are more semantic than real.

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[1] This Court has been faced previously with petitions for certiorari in cases involving the same issues presented here, one as recently as this year and two as recently as 2005, and has declined to grant the petitions in those cases. *See, e.g., Colucci v. AGFA Corp. Severance Pay Plan*, 431 F.3d 170 (4th Cir. 2005), *cert. denied*, 126 S.Ct. 2300 (2006); *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005); *Kobs v. United Wis. Ins. Co.*, 400 F.3d 1036 (7th Cir.), *cert. denied*, 126 S.Ct. 749 (2005); *Delta Family-Care Disability & Survivorship Plan v. Marshall*, 258 F.3d 834, 841 (8th Cir. 2001), *cert. denied*, 534 U.S. 1162 (2002); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1021, 1024 (7th Cir.), *cert. denied*, 525 U.S. 947 (1998); *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).

STATEMENT

After Respondent Peggy Hawkins-Dean became permanently disabled, she applied for benefits through the ERISA-governed company disability plan insured by Petitioner MetLife. Petitioner denied her claim for benefits, and Ms. Hawkins-Dean filed suit in the District Court. During the course of litigation, Petitioner reversed its position and conceded Ms. Hawkins-Dean's disability. The court remanded to Petitioner to calculate the amount of benefits, which according to the terms of the plan would be 60% of her monthly earnings.

Stock bonuses annually comprised a substantial portion of Ms. Hawkins-Dean's earnings, often exceeding her salary. Her W-2s reflect that she received stock and stock option income every year from 1995 through 1999. In 1995, Ms. Hawkins-Dean earned approximately $75,000 in salary and $48,000 in stock; in 1996, she earned a salary of $38,000 and $68,000 in stock; in 1997, $35,000 in salary and $85,000 in stock; in 1998, $24,000 in salary and $123,000 in stock; in 1999, $3,200 in salary and $60,000 in stock. R 129-133, SR 123-134.

Contrary to the terms of the Summary Plan Description ("SPD"), Petitioner determined that Ms. Hawkins-Dean's $123,000 in stock bonuses reported on her 1998 W-2 should not be considered in the calculation of her average monthly earnings. The SPD provides that a disabled employee is entitled to a monthly benefit equal to 60% of the monthly average of "earnings, **including . . . bonuses**, for the prior calendar year as reported by the Employer on Wage Form W-2. . . ." SR 9 (emphasis added). Rather than following the SPD and including bonuses, MetLife used a figure that it obtained from Ms. Hawkins-Dean's employer's

response to a MetLife questionnaire that asked for the amount of the employee's "Basic Earnings (exclusive of overtime, bonus, etc.)." SR 73. Ms. Hawkins-Dean repeatedly pointed out to MetLife that the number requested in its questionnaire was irrelevant because it specifically excluded "bonuses," a form of compensation specifically included in the SPD formula. MetLife repeatedly ignored Ms. Hawkins-Dean and the clear language of the SPD. R 121-22. Based on the much lower figure obtained from the questionnaire, Petitioner decided that Ms. Hawkins-Dean's monthly benefit, after taking a credit for her Social Security disability award, was only $152.50. SR 137.

Petitioner justifies its decision to ignore the value of the stock/stock options that appear on the 1998 W-2 by claiming that Ms. Hawkins-Dean "cash[ed] in company stock" in 1998 and shortly thereafter went out on disability. Pet. for Cert., 13-14. MetLife wrongly asserts that Ms. Hawkins-Dean's W-2 earnings for 1998 reflect a one-time "inflated" value and that to use the full earnings reflected on the 1998 W-2 would result in "windfall." Pet. For Cert. 5-6, 14. There is absolutely nothing in the administrative record prepared by MetLife supporting such an allegation. Indeed, the evidence establishes that Ms. Hawkins-Dean was not working for salary alone – her work earnings, every year, included company stock awards. Stock and stock options were a substantial part of her yearly earnings.

Ms. Hawkins-Dean again sought review in the District Court, which found that Petitioner had not abused its discretion in excluding the stock receipts from her benefits calculation. The Ninth Circuit reversed, finding that the calculation should have included the stock receipts.

REASONS FOR DENYING THE PETITION

A. The Ninth Circuit Has Overruled *Atwood*, Which Was the Decision on Which the Court Below Relied.

The petition for a writ of certiorari asks this Court to review a case, *Atwood*, that has now been overruled en banc by the Ninth Circuit in *Abatie*. "A conflict with a decision that has been discredited or that has lost all weight as authority because of intervening decisions of . . . the same court, will not be an adequate basis for granting certiorari." R. Stern & E. Gressman, SUPREME COURT PRACTICE 230 (8th ed. 2002).

Under *Atwood*, courts required that a participant come forward with "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show" that the administrator's decision was tainted by its conflict of interest. 45 F.3d at 1323. If the participant met this burden, and the administrator was unable to rebut this evidence, then the standard of review was de novo rather than for abuse of discretion. *Id.* at 1316, 1323.

In Petitioner's recital of the opinion below, Petitioner acknowledges that the decision "followed and applied the standard of review mandated by the Ninth Circuit's decision in *Atwood v. Newmont Gold Co.*, 45 F.3d 1317 (9th Cir. 1995)." Petitioner also argues that "the Ninth Circuit's approach is contrary to . . . this Court's decision in *Firestone*." Pet. for Cert., 9, citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) ("*Firestone*"). The *Abatie* court specifically overruled *Atwood*, determining that *Atwood* contradicted this Court's mandate in *Firestone*, 489 U.S. at 113. *Abatie*, 458 F.3d at 966-67. Petitioner's argument in favor of granting the petition is therefore

inapposite. *See Abatie*, 458 F.3d at 959 ("We conclude that our earlier opinion in *Atwood v. Newmont Gold Co.*, 45 F.3d 1317 (9th Cir.1995), misinterpreted *Firestone*.").

Firestone requires that a conflict of interest *must* be weighed in reviewing the discretionary decision of a conflicted fiduciary. 489 U.S. at 115. More recently, this Court confirmed the importance of judicial scrutiny where there is a conflict of interest, noting that "[i]n *Firestone Tire* itself we noted that review for abuse of discretion would home in on any conflict . . . if a conflict was plausibly raised." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n.15 (2002). This Court has also acknowledged that where the fiduciary has a financial interest in the claims decision, the "fiduciary capacity [is] necessarily compromised." *Pegram v. Herdrich*, 530 U.S. 211, 227 (2000).[2] The *Abatie* court held that *Atwood* did not follow the *Firestone* mandate. *Abatie*, 458 F.3d at 966-67. The *Abatie* court noted that the *Atwood* standard did not require courts to weigh conflicts of interest unless the participant could show the conflict tainted the decision-making process, in violation of *Firestone*. *Id.* The *Abatie* court also determined that *Atwood* violated *Firestone* because *Firestone* did not allow a de novo standard of review where discretionary language was present, which

[2] The RESTATEMENT (SECOND) OF TRUSTS also recognizes that a trustee can exercise discretionary power only if the trustee has complied with the duty of loyalty. *See* RESTATEMENT (SECOND) OF TRUSTS § 187(a) (trustee's "exercise of power is discretionary *except* to the extent to which its exercise is required . . . by the principles of law applicable to the duties of trustees," including § 170 (duty of loyalty)) (emphasis added). The duty of loyalty requires trustees to avoid conflicts of interest.

Atwood had permitted. *Id.* Therefore, Petitioner's question has been addressed by the Ninth Circuit.[3]

Because the *Abatie* court has redefined the Ninth Circuit's conflict of interest analysis to ensure that it adheres to the mandates of the *Firestone* decision, Petitioner's concerns have been addressed, and there is no need for Supreme Court review.

B. The Circuits State the *Firestone* Rule in Slightly Different Ways, But That Does Not Amount to A Conflict, Much Less An Important One.

There is no conflict among the circuits in weighing a claims administrator's conflicts of interest. Petitioner exaggerates the differences between the circuits and the significance of those differences. In applying *Firestone*, the circuits have all adopted some variation of a "sliding scale" approach when evaluating a decision made by a conflicted fiduciary, whereby the court "approximately calibrat[es] the intensity of our review to the intensity of the conflict." *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3d Cir. 2000); *see Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233-34 (4th Cir. 1997); *Vega v. National Life Ins. Servs.*, 188 F.3d 287, 297 (5th Cir. 1999) (en banc); *Borda v. Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, 1069 (6th Cir. 1998); *Chojnacki v. Georgia-Pacific Corp.*, 108

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[3] Petitioner also asks whether the Ninth Circuit erred in holding that the "administrator, not the participant, bears the burden of proof as to whether a conflict of interest tainted the administrator's benefits decision." Pet. for Cert., i. In fact, the Ninth Circuit did not so hold in this case. *See* Pet. for Cert., App. 2-3. Nonetheless, the *Abatie* court rejected *Atwood*'s burden-shifting regime. 458 F.3d at 973. Thus, the analysis of the decision below has been rendered obsolete by *Abatie*.

F.3d 810, 815 (7th Cir. 1997); *Clapp v. Citibank N.A. Disability Plan*, 262 F.3d 820, 827 (8th Cir. 2001); *Fought*, 379 F.3d at 1004-05, *cert. denied*, 544 U.S. 1026 (2005).[4]

Although the Ninth, Sixth, and First Circuits eschew the phrase "sliding scale," their approach to conflicts of interest is essentially the same, despite the different metaphors. In fact, the Ninth Circuit acknowledged that the approach it adopted in *Abatie* "is substantially similar to that adopted by several other circuits," despite rejecting the "sliding scale" metaphor. 458 F.3d at 967. In *Abatie*, the Ninth Circuit held that although abuse of discretion review applies "whenever an ERISA plan grants discretion to the plan administrator," that review must be tempered with "skepticism," with the conflict of interest being weighed more or less heavily depending on the conflict's "nature, extent, and effect on the decision-making process. . . ." 458 F.3d 955, 967-68. Although the Sixth Circuit also does not label its approach as a sliding scale, the result is the same, where the abuse of discretion standard of review may be "shaped" by evidence of a conflict of interest. *Borda*, 138 F.3d at 1069. The First Circuit requires that courts conduct an arbitrary and capricious review with "more bite," which is no different than a sliding scale. *See Janeiro v. Urological Surgery Professional Ass'n*, 457 F.3d 130, 142 (1st Cir 2006) (applying the level of "bite" necessary to account for the severity of the

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[4] Petitioner mis-characterizes the Fourth Circuit's standard for evaluating conflicts of interest as a "Restatement of Trusts § 187 Standard" rather than a sliding scale standard. *Compare* Pet. for Cert., 10-11 *with Ellis*, 126 F.3d at 233 ("It therefore appears that in no case does the court deviate from the abuse of discretion standard. Instead, the court modifies that abuse of discretion standard according to a sliding scale.").

conflict may require "no deference to the conflicted decisionmaker"); *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999) (holding that "fine gradations in phrasing are as likely to complicate as to refine the standard").

Only the Second and Eleventh Circuits employ a slightly different standard from the sliding scale model. In the Second Circuit, the plan participant must produce evidence that proves that the conflict of interest tainted the administrator's decision to receive anything but abuse of discretion review. *Sullivan v. LTV Aerospace and Defense Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996) (holding that plaintiffs have the burden of proving that the conflict of interest affected the administrator's decision). The Eleventh Circuit has determined that an administrator's financial conflict is an inherent and substantial conflict of interest and engages in a burden-shifting approach to enable the parties to demonstrate the extent of the conflict. *Brown*, 898 F.2d at 1561-62, *cert. denied*, 498 U.S. 1040, 1566-67 (1991). The Eleventh Circuit labels this approach as a "heightened arbitrary and capricious standard." *Torres v. Pittston Co.*, 346 F.3d 1324, 1334 (11th Cir. 2003); *see also HCA Health Services of Georgia, Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993 (11th Cir. 2001) ("The arbitrary and capricious deference is diminished, though, if the claims administrator was acting under a conflict of interest."); *Buckley v. Metro. Life*, 115 F.3d 936, 939 (11th Cir. 1997) (outlining that the Eleventh Circuit applies "heightened arbitrary and capricious where there is a conflict of interest"). Thus, this approach is not in substantial conflict with the other circuits.

C. Regardless of the Standard of Review, the Court Below Reached the Correct Result.

Supreme Court Rule 10 states that "[a] petition for a writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings. . . ." This Court has also stated that it "do[es] not grant a certiorari to review evidence and discuss specific facts." *United States v. Johnston*, 268 U.S. 220, 227 (1925). The specific amount of Ms. Hawkins-Dean's benefit is a finding of fact based on the underlying plan document and Ms. Hawkins-Dean's W-2 form. Reviewing this factual determination is not a "compelling reason" for the Court to grant Petitioner's request for a writ of certiorari. Petitioner nonetheless asks this Court to review a factual determination that Ms. Hawkins-Dean was entitled to benefits based on the earnings reported on her W-2 form. No matter what standard of review the court below would have applied, it made the correct factual determination.

Although the Ninth Circuit held that MetLife's denial of benefits should have been reviewed de novo, Ms. Hawkins-Dean would have prevailed even if the standard of review was for abuse of discretion. The only reasonable application of the plan's formula for determining benefits is the calculation that Ms. Hawkins-Dean sought and the Ninth Circuit ordered. MetLife's determination lacked factual foundation, as it was based on an irrelevant question in the company's questionnaire.

The SPD states that a disabled person covered by the plan is to receive a monthly benefit equal to "60% of Basic Monthly Earnings minus Other Income Benefits." R 80. "Basic Monthly Earnings" is defined as "the greater of (1) your **earnings**, **including** overtime **and bonuses**, for the

prior calendar year **as reported by the Employer on Wage Form W-2** averaged over the number of months of such W-2 earnings; and (2) your base monthly salary." R 90 (emphasis added). Ms. Hawkins-Dean became disabled in 1999. The prior calendar year, 1998, she earned, "**as reported by the Employer on Wage Form W-2,**" $151,854.97. R 123 (emphasis added). The monthly benefit due Ms. Hawkins-Dean under the plan is $7,592.75, less any applicable offsets ($151,853.97 X 60% / 12 = $7,592.75).

MetLife ignored the plan's formula for calculating benefits, and instead used Ms. Hawkins-Dean's base earnings to determine that it was only liable to pay Ms. Hawkins-Dean $152.50 per month. Ms. Hawkins-Dean's base salary represented only part of her "earnings" as defined in the SPD. "It is an abuse of discretion for an ERISA plan administrator to make a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Atwood*, 45 F.3d at 1323-24, *overruled on other grounds by Abatie*, 458 F.3d at 966.

MetLife contended that most of Ms. Hawkins-Dean's earnings reported by her employer on the W-2 for 1998 were stock options and "stock options are not referred to as among the types of compensation to be included in the calculation of Basic Monthly Earnings. Additionally, as per the terms of the SPD, the definition of Basic Monthly Earnings clearly does not include stock options so logically stock options are not included in the calculation." R 126. While stock and stock options are not specifically mentioned as part of "Basic Monthly Earnings," they are also not excluded from the definition. There is no logical basis for excluding stock and stock options from "Basic Monthly Earnings" since they are reflected in the W-2 and since the

SPD specifically includes "bonuses" within the definition of "Basic Monthly Earnings."

There is nothing in the four corners of the plan that says that a stock option is not a bonus. MERRIAM WEBSTER'S COLLEGIATE DICTIONARY (10th Ed. 1997) defines "bonus" as: "something in addition to what is expected or strictly due . . . money or an equivalent given in addition to an employee's usual compensation . . . a premium (as of stock) given by a corporation to a purchaser of its securities, to a promoter, or to an employee. . . ." *Id.* at 131. Moreover, the claims record shows that the award of stock and stock options to Ms. Hawkins-Dean in fact carried the label "bonus." Awards of restricted stock in 1997, 1996, and 1995 were each labeled as a "bonus holdback." SR 124, 126, 130. Therefore, the stock options, which were reported as income on Ms. Hawkins-Dean's W-2, are properly categorized as bonuses that are specifically included in calculating plan benefits.

Ms. Hawkins-Dean was not working for a salary alone. She was also working for the company stock.[5] The stock and stock options were the major source of her work earnings; the value of the stock and stock options exceeded her regular salary in 1996, 1997, 1998, and 1999. R 129-33. Ms. Hawkins-Dean's earning large sums in stock grants from her employer was not, as suggested by Amicus, a one-time deal. It was a yearly event and a substantial part of her earnings from her employer. If

[5] There can be no doubt that stock and stock options granted by an employer to its employees are a form of compensation for work. *Scully v. U.S. WATS, Inc.*, 238 F.3d 497, 508 (3d Cir. 2001); *Greene v. Safeway*, 210 F.3d 1237, 1243 (10th Cir. 2000); *In re Burlington Coat Factory Sec. Lit.*, 114 F.3d 1410, 1424 (3d Cir. 1997).

indeed the purpose of the plan is to protect the income of the plan beneficiaries should they become disabled, Ms. Hawkins-Dean had every reason to believe that the plan's protection extended to all of her work earnings, including the stock and stock options granted to her every year by her employer and reported on her W-2s.

Thus, regardless of the standard of review, "Basic Monthly Earnings" includes bonuses, and bonuses include stock options, so Ms. Hawkins-Dean was entitled to prevail. Therefore, the standard of review was not outcome-determinative in this case.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

CHARLES J. FLEISHMAN
8383 Wilshire Blvd., Suite 1030
Beverly Hills, CA 90211
(323) 653-9772

(4)

No. 05-1424

Supreme Court, U.S.
FILED
OCT 2 4 2006
OFFICE OF THE CLERK

In the Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY
AND
ROBERT HALF INTERNATIONAL, INC.,
PETITIONERS

v.

PEGGY HAWKINS-DEAN,
RESPONDENT

On Petition For A Writ Of Certiorari To The United States Court of Appeals for the Ninth Circuit

REPLY BRIEF IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI

GENE C. SCHAERR
GEOFFREY P. EATON
Winston & Strawn LLP
1700 K Street, N.W.
Washington, D.C. 20006
(202) 282-5000
LINDA T. COBERLY
Winston & Strawn LLP
35 West Wacker Drive
Chicago, Illinois 60601
(312) 558-5600
AMY K. POSNER
Metropolitan Life Insurance Company
27-01 Queens Plaza North
Long Island City, NY 11101
(212) 578-8296

LEE T. PATERSON
Counsel of Record
AMANDA C. SOMMERFELD
Winston & Strawn LLP
333 South Grand Ave.
Los Angeles, CA 90071
(213) 615-1700

Counsel for Petitioners

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D.C. 20001

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTRODUCTION 1

I. *Abatie* Itself Establishes That The Existing Circuit Conflict Is Wide, Deep, Mature And Important. 2

II. This Case Is An Excellent Vehicle With Which To Resolve The Existing, Acknowledged Circuit Conflict. 7

III. In The Alternative, Because The Ninth Circuit Held After The Filing Of This Petition That The Standard Of Review It Applied In This Case Misinterprets *Firestone*, The Court Should Grant, Vacate And Remand. 8

CONCLUSION 10

TABLE OF AUTHORITIES

Page(s)

CASES:

Abatie v. *Alta Health & Life Ins. Co.*,
458 F.3d 955 (9th Cir. 2006) ..... *passim*

Atwood v. *Newmont Gold Co.*,
45 F.3d 1317 (9th Cir. 1995) 1, 4, 9

Borda v. *Hardy, Lewis*, 138 F.3d 1062 (6th Cir. 1998) 4

Brown v. *Blue Cross & Blue Shield, Inc.*,
898 F.2d 1556 (11th Cir. 1990) 1

Davis v. *Kentucky Fin. Cos. Retirement Plan*,
887 F.2d 689 (6th Cir. 1989) 3

Doe v. *Travelers Ins. Co.*, 167 F.3d 53 (1st Cir. 1999) 3

Firestone v. *Bruch*, 489 U.S. 101 (1989) ..... *passim*

Fought v. *UNUM Life Ins. Co. of Am.*,
379 F.3d 997 (10th Cir. 2004),
cert. denied, 544 U.S. 1026 (2005) 1

Gismondi v. *United Techs. Corp.*,
408 F.3d 295 (6th Cir. 2005) 3

Griffith v. *Kentucky*, 479 U.S. 314 (1987).....10

HCA Health Servs., Inc. v. *Employers Health Ins. Co.*,
240 F.3d 982 (11th Cir. 2001) 2

Janeiro v. *Urological Surgery Professional Ass'n*,
457 F.3d 130 (1st Cir. 2006).....3

Kunin v. *Benefit Trust Life Ins. Co.*,
910 F.2d 534 (9th Cir. 1990) 7

Lawrence v. *Chater*, 516 U.S. 163 (1996)..... 8-9

Mario v. *P & C Food Mkts.*,
313 F.3d 758 (2d Cir. 2002) 6

Pagan v. *NYNEX Pension Plan*,
52 F.3d 438 (2nd Cir. 1995) 6

Pegram v. *Herdrich*, 530 U.S. 211 (2000) 5

Peruzzi v. *Summa Medical Plan*,
137 F.3d 431 (6th Cir. 1998) 3-4

Pinto v. *Reliance Std. Life Ins. Co.*,
214 F.3d 377 (3rd Cir. 2000) 6

Rud v. *Liberty Life Assurance Co.*,
438 F.3d 772 (7th Cir. 2006) 2

Rush Prudential HMO, Inc. v. *Moran*,
536 U.S. 355 (2002) 5

State Farm Mut. Auto. Ins. Co. v. *Duel*,
324 U.S. 154 (1945) 8

Sullivan v. *LTV Aerospace & Def. Co.*,
82 F.3d 1251 (2d Cir. 1996) 2

Wallace v. *Reliance Standard Life Ins. Co.*,
318 F.3d 723 (7th Cir. 2003) 6

Whitney v. *Empire Blue Cross & Blue Shield*,
106 F.3d 475 (2d Cir. 1997) 1

Wright v. *R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67 (1st Cir. 2005) 2

STATUTES:

28 U.S.C. § 2106 8

MISCELLANEOUS:

Donald Bogan & Benjamin Fu, *No Further Inquiry into a Conflicted Plan Administrator Claim Denials*,
58 Okla. L. Rev. 637 (2005) 7

James Bradley Thayer, *A Preliminary Treatise on Evidence at the Common Law* (1898) 4

McCormick on Evidence § 344 (6th ed. 2006) 4

INTRODUCTION

Nothing in Respondent's opposition, or in the Ninth Circuit's recent decision in *Abatie* v. *Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006) (*en banc*) ("*Abatie*"), casts any serious doubt on the urgent need for this Court to resolve the persistent circuit conflict over the impact of an "inherent" conflict of interest on judicial review of benefit decisions by ERISA plan administrators.

As explained in our petition, the circuits take three very different approaches to that question. The first approach, which we have called the "Restatement §187" approach, requires a court to affirm "a reasonable interpretation of the Plan . . . unless the *participants* can show not only that a potential conflict of interest exists, ... but that the 'conflict *affected* the reasonableness of the [plan's] decision.'" *Whitney* v. *Empire Blue Cross & Blue Shield*, 106 F.3d 475, 477 (2d Cir. 1997) (emphasis added). The second, sometimes called the "sliding scale approach," holds that "the court must decrease the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict." *Fought* v. *UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1004 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005). And the third or "presumptively void" approach requires a reviewing court to apply a *de novo* standard unless the *administrator* affirmatively establishes that the potential conflict did *not* affect its decision. *E.g.*, *Brown* v. *Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1567 (11th Cir. 1990). In *Abatie*, the Ninth Circuit moved from the third approach to the second—and in so doing openly acknowledged that the legal standard applied in *this* case (and articulated in *Atwood* v. *Newmont Gold Co.*, 45 F.3d 1317 (9th Cir. 1995)) conflicts with *Firestone* v. *Bruch*, 489 U.S. 101 (1989).

Respondent's effort to minimize the importance of this three-way conflict falls wide of the mark, as does her suggestion that this case is not a good vehicle with which to resolve that conflict.

I. *Abatie* Itself Establishes That The Existing Circuit Conflict Is Wide, Deep, Mature And Important.

Respondent concedes (Opp. at 8) that the Second and Eleventh circuits both employ a "different standard" from the model now employed by the Ninth Circuit. Yet Respondent attempts to minimize the resulting conflict by contending (1) that the Second and Eleventh are the "only" circuits that now apply a different standard and (2) that the standards in those circuits are only "slightly different" from the sliding scale approach. *Id.* Both assertions are incorrect.

1. In *Abatie*, the Ninth Circuit stated clearly that its new standard conflicts with decisions in the First, Second, Seventh and Eleventh Circuits.[1] *Abatie at* n. 6. The Ninth Circuit

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[1] The following passage from *Abatie* describes the contrary precedent: "Other circuits have developed *different* approaches to determine the applicable standard of review in ERISA benefits denial cases. *See, e.g., Rud* v. *Liberty Life Assurance Co.*, 438 F.3d 772, 777 (7th Cir. 2006) (holding that a structural conflict of interest, without more, does not affect the standard of review and requiring the claimant to prove that the alleged conflict affected the administrator's decision); *Wright* v. *R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74 (1st Cir. 2005) (holding that an inherent conflict of interest does not necessarily affect the abuse of discretion standard, and placing the burden on the claimant to demonstrate that a conflict exists); *HCA Health Servs., Inc.* v. *Employers Health Ins. Co.*, 240 F.3d 982, 993-94 (11th Cir. 2001) (applying *de novo* review, initially, to decide whether the claim was wrongly decided, and if an inherent conflict of interest exists, requiring the administrator to prove that its interpretation was not tainted by self-interest); *Sullivan* v. *LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (requiring a claimant to show that a conflict of interest affected the reasonableness of the administrator's decision; if the claimant carries that burden then *de novo* review applies). *Abatie* at n.6. This passage is a clear acknowledgement of the persistent circuit conflict.

Disputing the *Abatie* holding, in part, Respondent argues (Opp. at 7) that the First Circuit actually applies a "sliding scale"

also noted that its approach is similar to that of the Third, Fourth, Fifth, Eighth and Tenth Circuits. *Id.* at 964-965.[2] Thus, even according to the Ninth Circuit, the current breakdown among the Circuits is 3-6-1 – a very wide split.

Moreover, as explained in the petition, the Sixth Circuit also applies a "Restatement § 187" approach. *See* Petition at 11 (discussing *Peruzzi* v. *Summa Medical Plan*, 137 F.3d 431, 433 (6th Cir. 1998)); *see also Davis* v. *Kentucky Fin. Cos. Retirement Plan*, 887 F.2d 689, 694 (6th Cir. 1989); *Gismondi* v. *United Techs. Corp.*, 408 F.3d 295, 299 (6th Cir. 2005).[3] Thus,

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approach rather than the "Restatement § 187" approach applied by the Second and other circuits. But she is wrong. One of the two decisions on which Respondent relies—*Doe* v. *Travelers Ins. Co.*, 167 F.3d 53 (1st Cir. 1999)—expressly *rejected* a variant of the sliding scale approach, a variant that calls on courts to apply abuse of discretion review with "more bite" in the face of a structural conflict. Instead, the Court held that the "requirement that [the administrator's] decision be 'reasonable' is the basic touchstone in a case of this kind and ... fine gradations in phrasing are as likely to complicate as to refine the standard." *Id.* at 57. And the other decision—*Janeiro* v. *Urological Surgery Professional Ass'n*, 457 F.3d 130 (1st Cir. 2006) - reiterated the First Circuit's long-standing position that "structural conflicts alone—those arising from the administrator's . . . own financial interests—are not sufficient to abandon the normal highly deferential review." *Id.* at 139 (citing *Wright, supra*). Both decisions thus conflict with the Ninth Circuit's holding in *Abatie* that a structural conflict requires something less than "the normal highly deferential review."

[2] In *Abatie*, the Ninth Circuit also injected into single-plaintiff benefits cases broad, class-action type discovery. It stated that, regardless of the reasonableness of the administrator's decision, where a "structural" conflict exists, the plaintiff may conduct wide-ranging discovery, outside the administrative record, to determine whether there is "evidence of malice, of self-dealing, or of a parsimonious claims-granting history." *Abatie*, 458 F.3d at 968.

[3] Respondent is likewise incorrect in contending (Opp. at 7) that the Sixth Circuit's standard is "essentially the same" as the Ninth

even with the Ninth Circuit's recent change of mind, the circuit split currently stands at 4-6-1. And we are aware of no indication that any other circuit is poised to reconsider its position on this critical issue.

2. Respondent is also incorrect in claiming that the "Restatement § 187" and "presumptively void" approaches are only "slightly different" from each other and from the "sliding scale" approach (Opp. at 8) or, as Respondent puts it elsewhere, that the differences "are more semantic than real" (Opp. at 1). Contrary to Respondent's argument, the Ninth Circuit obviously thought the difference between its prior "presumptively void" approach and its new approach was sufficiently important to resolve in an *en banc* proceeding, and to reverse a decade-old precedent (*Atwood*) that had been applied in more than 50 subsequent cases. And the Ninth Circuit thought the difference between its approach and the "Restatement § 187 " approach—which effectively accords a presumption of validity to the administrator's decision—was important enough to expressly reject the latter standard. See *supra* n. 1.

The differences among these approaches, therefore, are more than merely semantic. As any experienced litigator knows, and a vast body of law confirms, presumptions do matter. *See, e.g., McCormick on Evidence* § 344 (6th ed. 2006) (describing effects of presumptions in civil cases and noting that presumptions are "engrained in the law"); James Bradley Thayer, *A Preliminary Treatise on Evidence at the Common*

Circuit's approach in *Abatie*. *Peruzzi*, which Respondent does not address, refutes that suggestion. And the lone Sixth Circuit case Respondent does cite–*Borda* v. *Hardy, Lewis*, 138 F.3d 1062 (6th Cir. 1998)—merely noted earlier dictum to the effect that application of the arbitrary and capricious standard "should be shaped by the circumstances of the inherent conflict of interest." *Id.* at 1069. The court then went on to *reject* the plaintiff's attack on the trustee's decision, concluding that it could not be overturned "without bending the standard entirely out of shape." *Id.*

Law 314 (1898) (noting importance of presumptions not only to evidence law but to the "much larger topic . . . of legal reasoning" itself). Thus, the "Restatement § 187" approach—which says that an administrator's decision will be subject to deferential review unless the *plaintiff* demonstrates that the potential conflict had an *actual* effect on the decision—is much more likely to result in a decision in favor of the administrator than the polar opposite "presumptively void" standard, i.e., that the decision is presumed unreasonable unless the ERISA *administrator* proves that the potential conflict did *not* affect the decision. [4]

These contrasting standards are also likely to produce substantially different results in real-life litigation than the standard adopted by the Ninth Circuit in *Abatie*, i.e., that an administrator's decision will be treated more deferentially the more "minor" the conflict is, and less deferentially the more "egregious" the conflict is. 458 F.3d at 968. Given the inherent difficulty of applying deference by degrees, the *Abatie* standard very likely means, in practical effect, that a reviewing court will engage in *either* deferential or *de novo*

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[4] The Court clearly outlined this issue in *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 384 n.15 (2002) "An issue implicated by this case but requiring no resolution is the degree to which a plan provision for unfettered discretion in benefit determinations guarantees truly deferential review. In *Firestone Tire* itself, we noted that review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised. That last observation was underscored only two Terms ago in *Pegram* v. *Herdrich*, 530 U.S. 211, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000), when we again noted the potential for conflict when an HMO makes decisions about appropriate treatment, *see id.*, at 219-220, 120 S. Ct. 2143. It is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest. Moreover, as we explained in *Pegram*, 'it is at least questionable whether Congress would have had mixed eligibility decisions in mind when it provided that decisions administering a plan were fiduciary in nature.'" *Id.* at 232.

review, after the court evaluates the conflict and the evidence supporting and opposing the administrator's benefit decision. Thus, in any given case, that standard will likely produce a result that is the opposite of either the "presumptively void" standard or the Restatement § 187 standard.

3. Nor can there be any doubt that this circuit conflict is desperately in need of resolution. In the seventeen years since *Firestone*, literally hundreds of judges have devoted hundreds of pages discussing the meaning of one sentence of dicta in that decision: "[o]f course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' Restatement (Second) of Trusts 187, Comment *d* (1959).'" *Firestone*, 489 U.S. at 957. As demonstrated above and in the petition, the circuits have virtually all attempted but failed to settle on a single interpretation of that sentence. And several decisions have urged this Court to resolve the issue.[5]

Resolution of the circuit split is also urgently needed as a matter of simple fairness: As a result of the present conflict, administrators of national benefit plans now face at least three separate standards of review in the circuit courts. Thus, the same type of benefit decision can be approved in one circuit and rejected in another based solely on the standard of review employed by that circuit. Only this Court

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[5] *E.g.*, *Mario* v. *P & C Food Mkts.*, 313 F.3d 758, 763 n.3 (2d Cir. 2002) (noting that "[t]he correctness—and wisdom—of the *Firestone* decision . . . has been cogently challenged by the country's leading ERISA scholar); *Pinto* v. *Reliance Std. Life Ins. Co.*, 214 F. 3d 377, 383 (3rd Cir. 2000); *Pagan* v. *NYNEX Pension Plan*, 52 F. 3d 438, 442 (2nd Cir. 1995); *Wallace* v. *Reliance Standard Life Ins. Co.*, 318 F. 3d 723, 724 (7th Cir. 2003). Needless to say, we believe that *Firestone* was correctly decided, and that what we have called the "Restatement § 187 approach" is most consistent with that decision as well as the underlying statute. *See* Petition at 14.

can bring resolution to this issue. As two scholars have recently put it, "[t]he fact that different judges, sometimes within the same circuit, still disagree about what *Firestone* requires, reinforces the drastic need to clarify and simplify this chaos." Donald Bogan & Benjamin Fu, *No Further Inquiry into a Conflicted Plan Administrator Claim Denials*, 58 Okla. L. Rev. 637, 655 (2005).

II. This Case Is An Excellent Vehicle With Which To Resolve The Existing, Acknowledged Circuit Conflict.

This case is also a compelling vehicle for resolution of the conflict. The relevant facts are well developed and the issues clearly defined. Moreover, contrary to Respondent's argument (Opp. at 9-12), the different alternative standards likely *would* have an impact on the resolution of this case. Respondent's assertion to the contrary— that "the *only* reasonable application of the plan's formula for determining benefits is the calculation Ms. Hawkins-Dean sought and the Ninth Circuit ordered" (Opp. at 9) (emphasis added)—flatly misreads the Ninth Circuit opinion and the record below.

To be sure, the Ninth Circuit reviewed the record and found, contrary to the district court, that Respondent had provided evidence of a conflict of interest which Petitioner failed to rebut.[6] However, contrary to Respondent's assertion, the Circuit did *not* find only one reasonable application of the plan language. In fact, the Circuit was forced to use a rule of contract interpretation, *contra proferentem*, which applies only when necessary to resolve a conflict between *two* reasonable interpretations of the benefit plan. Pet. App. 3; see, *e.g.*, *Kunin* v. *Benefit Trust Life Ins. Co.*, 910 F.2d 534, 539 (9th Cir. 1990) ("A typical statement of the rule is that if, af-

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[6] Aside from the "structural" conflict inherent in the fact that the administrator was also funding the benefits, the sole evidence of conflict was Petitioner's change of mind in *favor* of Respondent's eligibility for benefits. Still the Circuit reviewed the administrator's decision *de novo*.

ter applying the normal principles of contractual construction, the insurance contract is fairly susceptible of two different interpretations, another rule of construction will be applied: the interpretation that is most favorable to the insured will be adopted.") (Citation omitted).

Thus, the Ninth Circuit's own decision in this case establishes that Petitioner's reading of the plan was reasonable, and therefore that Petitioner's action would have been upheld under the kind of unqualified reasonableness standard applied in the First and Second Circuits, among others. And because the conflict of interest is not a serious one (see Pet. App. 2), Petitioner's action would likely be upheld under the "sliding scale" standard applied in several other circuits. Accordingly, this case provides an ideal vehicle by which the Court can choose among the various approaches and, in so doing, resolve the circuit conflict outlined above.

III. In The Alternative, Because The Ninth Circuit Held After The Filing Of This Petition That The Standard Of Review It Applied In This Case Misinterprets *Firestone*, The Court Should Grant, Vacate And Remand.

If the Court nevertheless declines to hear the case on its merits, Petitioner requests that the Court grant the Petition, vacate the Ninth Circuit's decision and remand for further proceedings. This Court routinely exercises its power to grant, vacate and remand (28 U.S.C. § 2106) when a supervening event "alters the basis upon which the judgment rests. . ." *State Farm Mut. Auto. Ins. Co.* v. *Duel*, 324 U.S. 154, 161 (1945). Indeed, in *Lawrence* v. *Chater*, 516 U.S. 163, 165-167 (1996) (*per curiam*), the Court made clear that the grant, vacate and remand procedure is appropriate where three conditions are satisfied:

(1) there are "intervening developments";

(2) these developments give rise to "a reasonable probability that the decision below rests upon a

premise that the lower court would reject if given the opportunity for further consideration"; and

(3) "such a redetermination may determine the ultimate outcome of the litigation."

Id. at 167. Each of these requirements is satisfied here.

First, there has been an important intervening development, specifically, the holding by the Ninth Circuit, after the filing of our petition, that the standard of review applied in this case was incorrect. In the decisions below, the Ninth Circuit and the District Court relied upon the "presumptively void" standard of review adopted in *Atwood*. However, in *Abatie*, the Ninth Circuit overruled *Atwood* "in its entirety." *Abatie* at 967. In so doing, the Ninth Circuit repeatedly acknowledged that the *Atwood* standard conflicts with this Court's decision in *Firestone*: "*Atwood* ignores the Supreme Court's requirement that a court weigh as a 'factor' in abuse of discretion review the conflict of interest that inheres when a plan administrator also acts as its fiduciary." *Id.* at 966. Moreover, "*Atwood*'s back-and-forth burden shifting disobeys the Supreme Court's guidance." *Id.*

Second, it is not merely probable, but certain, that if this case were being heard today by a Ninth Circuit panel, it would reject *Atwood* and apply the *Abatie* standard.

Third, a remand *may* determine the ultimate outcome of this litigation because, under the *Abatie* decision, there is no necessary presumption that the administrator's decision was wrong. Thus, although petitioner believes that the costs of a remand (which would delay resolution of the circuit conflict described above) far outweigh any benefit to this Court of yet another decision from the Ninth Circuit,[7] it is possible

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[7] As the Court stated in *Lawrence*, "if the delay and further cost entailed in a remand are not justified by the potential benefits of further consideration by the lower court, a GVR order is inappropriate." 516 U.S. at 168.

that the Ninth Circuit would reach the correct result if this case were remanded.

Finally, as the Court pointed out in *Griffith* v. *Kentucky*, 479 U.S. 314, 323 (1987), if the Court is unwilling to grant plenary review, a failure to remand under these circumstances "violates the principle of treating similarly situated defendants the same . . .".

For all of these reasons, the Court should grant the petition, and vacate and remand the judgment below, if the Court does not wish to grant plenary review.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

GENE C. SCHAERR
GEOFFREY P. EATON
Winston & Strawn LLP
1700 K Street, N.W.
Washington, D.C. 20006
(202) 282-5000
LINDA T. COBERLY
Winston & Strawn LLP
35 West Wacker Drive
Chicago, Illinois 60601
(312) 558-5600
AMY K. POSNER
Metropolitan Life Insurance Company
27-01 Queens Plaza North
Long Island City, NY 11101
(212) 578-8296

LEE T. PATERSON
Counsel of Record
AMANDA C. SOMMERFELD
Winston & Strawn LLP
333 South Grand Ave.
Los Angeles, CA 90071
(213) 615-1700

Counsel for Petitioners

MOTION FILED
JUN 8 - 2006

(2)

No. 05-1424

IN THE
Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY,

Petitioner,

v.

PEGGY HAWKINS-DEAN,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF OF *AMICUS CURIAE* THE AMERICAN COUNCIL OF LIFE INSURERS IN SUPPORT OF PETITIONER AND BRIEF OF *AMICUS CURIAE*

CARL B. WILKERSON
Vice President & Chief Counsel, Securities & Litigation
LISA TATE
Senior Counsel, Litigation
AMERICAN COUNCIL OF LIFE INSURERS
101 Constitution Ave., N.W.
Suite 700
Washington, D.C. 20001-2133
(202) 624-2153

RICHARD B. LAZARUS
Counsel of Record
CAROLYN DOPPELT GRAY
TERESA L. JAKUBOWSKI
BARNES & THORNBURG LLP
750 17th Street, N.W.
Washington, D.C. 20006
(202) 289-1313

Counsel for Amicus Curiae

201640

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

MOTION FOR LEAVE TO FILE BRIEF OF *AMICUS CURIAE*

The American Council of Life Insurers ("ACLI") hereby moves, pursuant to Rule 37.2 of the Supreme Court of the United States, for leave to file a brief as *amicus curiae* in support of Metropolitan Life Insurance Company's petition for writ of certiorari, No. 05-1424, to the United States Court of Appeals for the Ninth Circuit. Counsel for petitioner, Metropolitan Life Insurance Company, has consented to ACLI's filing an amicus brief in support of the petition. Counsel for respondent, Peggy Hawkins-Dean, was contacted on June 1, 2006 and declined to consent, thus necessitating this motion. A copy of ACLI's proposed amicus brief is attached.

ACLI is the largest life insurance trade association in the United States, representing the interests of 377 member legal reserve life insurers operating in the United States. These 377 member companies account for 91 percent of the industry's total assets, 90 percent of life insurance premiums in the United States among legal reserve life insurance companies, and 95 percent of annuity considerations. The life insurance policies issued by ACLI members include employer-sponsored group disability insurance policies and group life policies. The annuities issued include group annuities issued to employer-sponsored retirement plans. The vast majority of the products sold by ACLI members in the group employee benefits market are subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA").

The ACLI is, accordingly, well-positioned to address the questions presented from the perspective of the insurance industry. ACLI seeks to file the proposed brief, and believes the brief can assist the Court, because the questions presented in the petition present significant issues for the industry as a whole and have practical ramifications far beyond the disposition of this particular case. The ongoing conflict and confusion among the circuit courts of appeals regarding the standard of review

applicable under ERISA when an insurer, or any other administrator or fiduciary, is operating under an alleged conflict of interest significantly impact the manner and cost of operating employer-sponsored benefit plans and undermine the "uniformity of regulation" Congress sought to achieve in enacting ERISA.

The Ninth Circuit's decision to include a beneficiary's profit from the exercise of stock options as part of an employee's "basic monthly earnings" in calculating the benefits due under the plan also raises significant public policy concerns for the funding and underwriting of benefit plans, such as disability income plans and pension or retirement plans. As set forth in the brief, the Ninth's Circuit's decision is at odds with both the public policies underlying the benefit levels set forth in long-term disability plans and the manner in which policies funding such plans are priced and sold. These concerns should be before this Court for a proper evaluation of the questions presented.

Therefore, the ACLI respectfully requests that the Court grant leave to file the attached brief.

Respectfully submitted,

CARL B. WILKERSON
Vice President & Chief Counsel, Securities & Litigation
LISA TATE
Senior Counsel, Litigation
AMERICAN COUNCIL OF LIFE INSURERS
101 Constitution Ave., N.W.
Suite 700
Washington, D.C. 20001-2133
(202) 624-2153

RICHARD B. LAZARUS
Counsel of Record
CAROLYN DOPPELT GRAY
TERESA L. JAKUBOWSKI
BARNES & THORNBURG LLP
750 17th Street, N.W.
Washington, D.C. 20006
(202) 289-1313

Counsel for Amicus Curiae

TABLE OF CONTENTS

	Page
Table Of Cited Authorities	iii
Interest of *Amicus Curiae*	1
Summary of Argument	2
Reasons for Granting the Petition	3
A. The Circuit Courts Of Appeals Have Not Resolved Their Conflicting Standards Of Review In The Context Of Conflicted Administrators Or Fiduciaries	3
B. The Conflict Among The Circuits Undermines Basic Erisa Policies And Adversely Affects Employee Benefit Plans	9
1. The Standard of Review Issue Affects A Large Proportion of ERISA Litigation	9
2. The Conflict Undermines the National Uniform Regulation Intended by ERISA, and Consequently Increases the Cost to Employers of Providing Benefit Plans	11
3. The Circuit Conflict Undermines ERISA's Civil Enforcement Scheme, Increasing Litigation and Consequently Further Increasing the Cost to Employers of Providing Benefit Plans	12

Contents

Page

4. The Conflict Negatively Impacts Benefit Plans and Employers in Additional Ways 13

C. A Traditional Deferential Standard Of Review Should Apply 15

D. The Ninth Circuit's Inclusion Of Stock Option Profits In "Basic Monthly Earnings" For Purposes Of Calculating Plan Benefits Raises Significant Public Policy Concerns 18

Conclusion 20

TABLE OF CITED AUTHORITIES

Page

CASES

Alford v. DCH Foundation Group Long Term Disability Plan,
311 F.3d 955 (9th Cir. 2002) 10

Armstrong v. Aetna Life Ins. Co.,
128 F.3d 1263 (8th Cir. 1997) 8

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45 F.3d 1317 (9th Cir. 1995) 5

Barnhart v. UNUM Life Ins. Co. of Am.,
179 F.3d 583 (8th Cir. 1999) 8

Black & Decker Disability Plan v. Nord,
538 U.S. 822 (2003) 16

Brown v. Blue Cross & Blue Shield of Alabama, Inc.,
898 F.2d 1556 (11th Cir. 1990) 6, 7, 8

Bruch v. Firestone Tire and Rubber Co.,
828 F.2d 134 (3d Cir. 1987), *rev'd,*
489 U.S. 101 (1989) 4

Chambers v. Family Health Plan Corp.,
100 F.3d 818 (10th Cir. 1996) 7, 10

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12 Fed.Appx. 277, 2001 WL 392050
(6th Cir. 2001) 10

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Page

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206 F.3d 806 (8th Cir. 2000) 5, 10

Doe v. Group Hospitalization & Med. Servs.,
3 F.3d 80 (4th Cir. 1993) 7

Doe v. Travelers Ins. Co.,
167 F.3d 53 (1st Cir. 1999) 8, 9

Firestone Tire & Rubber Co. v. Bruch,
489 U.S. 101 (1989) 2, 3, 4, 9

Fort Halifax Packing Co. v. Coyne,
482 U.S. 1 (1987) 2, 12

Fought v. UNUM Life Ins. Co. of Am.,
379 F.3d 997 (10th Cir. 2004), *cert. denied*,
125 S. Ct. 1972 (2005) 7, 8

Hung v. Guardian Life Ins. Co. of Am.,
28 Fed. Appx. 268, 2002 WL 104234
(4th Cir. 2002) 10

Ingersoll-Rand Co. v. McClendon,
498 U.S. 133 (1990) 12

Johannsen v. District No. 1— Pacific Coast Dist., MEBA Pension Plan,
292 F.3d 159 (4th Cir. 2002) 10

Lang v. Long Term Disability Plan of Sponsor Applied Remote Tech. Inc.,
125 F.3d 794 (9th Cir. 1997) 10

Cited Authorities

Page

Leipzig v. AIG Life Ins. Co.,
362 F.3d 406 (7th Cir. 2004) 5, 17

Levinson v. Reliance Standard Life Ins. Co.,
245 F.3d 1321 (11th Cir. 2001) 5, 7, 10

Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan,
144 F.3d 1014 (7th Cir. 1998) 6, 10, 17

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,
514 U.S. 645 (1995) 11

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296 F.3d 823 (9th Cir. 2002), *rev'd on other ground*, 538 U.S. 822 (2003) 6

Pegram v. Herdrich,
530 U.S. 211 (2000) 16

Perlman v. Swiss Bank Corp.,
195 F.3d 975 (7th Cir. 1999) 5

Peruzzi v. Summa Med. Plan,
137 F.3d 431 (6th Cir. 1998) 6, 10

Phillips-Foster v. UNUM Life Ins. Co. of Am.,
302 F.3d 785 (8th Cir. 2002) 8

Pilot Life Ins. Co. v. Dedeaux,
481 U.S. 41 (1987) 12

Cited Authorities

	Page
Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377 (3d Cir. 2000)	7, 10
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Woo v. Deluxe Corp., 144 F.3d 1157 (8th Cir. 1998)	8
Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan, 402 F.3d 67 (1st Cir. 2005)	5
STATUTES	
29 U.S.C. § 1001b(c)	11
29 U.S.C. § 1108(c)	15
29 U.S.C. § 1132(a)(1)(B)	3, 4
OTHER AUTHORITIES	
H.R. Rep. No. 93-533, at 9 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639	11
Restatement (Second) of Trusts § 187	4

INTEREST OF *AMICUS CURIAE*

As noted in the accompanying motion, the American Council of Life Insurers ("ACLI")[1] is the largest life insurance trade association in the United States. The life insurance policies issued by ACLI members include employer-sponsored group disability insurance policies and group life policies. The vast majority of the products sold by ACLI members in the group employee benefits market are subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA").

Of substantial concern to ACLI and its members is the ongoing conflict and confusion among the circuit courts of appeals regarding the standard of review applicable under ERISA to actions alleging denial of benefits when an insurer, or any other administrator or fiduciary, is operating under an alleged conflict of interest. This conflict is the subject of Questions 1 and 2 of the petition of Metropolitan Life Insurance Company ("petitioner" or "MetLife") for a writ of certiorari. ACLI is uniquely positioned to explain the practical ramifications of this conflict upon employer-sponsored benefit plans, and hence the need for the Court to resolve this conflict.

The Ninth Circuit's decision that a beneficiary's profit from the exercise of stock options must be included as "basic monthly earnings" in calculating the benefits due under the plan also is equally of concern to the ACLI and its members. The Ninth Circuit's decision raises significant public policy concerns for the funding and underwriting of benefit plans such as disability income plans and pension or retirement plans.

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1. Pursuant to Rule 37.6 of the Rules of the U.S. Supreme Court, the ACLI's counsel of record hereby certifies that this brief was authored in whole by Barnes & Thornburg LLP, and that no individual or entity other than the ACLI has contributed monetarily to the preparation of this brief.

SUMMARY OF ARGUMENT

ACLI respectfully urges the Court to grant the petition. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court held that a deferential standard of review is applicable to ERISA actions challenging denial of benefits where the benefit plan confers upon the administrator or fiduciary discretionary authority to determine eligibility for benefits or construe plan terms. In the 17 years since *Firestone* was decided, the lower federal courts have failed to develop a consistent, cohesive approach to applying that standard of review where an administrator or fiduciary of the benefit plan, whether it be an insured or a self-funded plan, is operating under an alleged conflict of interest. The result has been a widespread and deepening conflict among the circuit courts of appeals with respect to the degree of deference to be afforded in such circumstances. The various approaches adopted range from showing a high degree of deference to showing, as in the instant case, no deference at all and applying a *de novo* standard of review.

The standard of review in cases of conflicted administrators and fiduciaries concerns all insured plans and all plans that are both self-funded and self-administered, and hence a large proportion of ERISA actions brought in federal court alleging wrongful denial of benefits. The existing disarray among the circuits is particularly problematic because it severely undermines Congress' key objective in enacting ERISA – to establish a "uniform administrative scheme" for ERISA-covered benefit plans and a uniform body of federal common law for enforcement of such plans. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Congress sought to establish this uniformity as part of its effort to encourage employers to establish benefit plans by eliminating the difficulties presented by and increased costs resulting from a patchwork of conflicting state and local laws. The disarray among the circuits also undercuts another congressional objective in enacting ERISA – providing an efficient, cost-effective enforcement scheme for the administration of benefit claim decisions.

As a practical matter, the lack of uniformity among the circuits on this issue is problematic because the multitude of approaches taken by the circuits leaves plans that wish to retain a traditional degree of discretion in making claims decisions without any clear guidance as to how the plan should be structured so that discretion can be preserved. Indeed, the only fail-safe position for doing so would appear to be self-funding the plan and hiring an independent third party administrator to render benefit determinations. Although this may be an option for large employers, medium and smaller employers are unlikely to have the necessary financial resources or infrastructure to self-fund a benefit plan.

ACLI also respectfully urges the Court to grant the petition with respect to Question 3 regarding the inclusion of profits from the exercise of stock options as "basic monthly earnings" in the calculation of plan benefits due to the significant public policy concerns the Ninth Circuit's decision raises. While the intended purpose of long term disability plans is to replace a portion of beneficiaries' normal earnings stream in the event of a qualifying disability, the Ninth Circuit's formulation of "earnings" can result in beneficiaries receiving benefits far in excess of their normal earnings stream. Herein, respondent's annual benefits (exclusive of offsets for certain other income or benefits) will exceed $91,000, even though her pre-disability annual income was only $28,850. It also raises significant issues in funding and underwriting such plans, given the vagaries in stock market valuation and beneficiaries' unpredictable actions and timing in exercising stock options.

REASONS FOR GRANTING THE PETITION

A. THE CIRCUIT COURTS OF APPEALS HAVE NOT RESOLVED THEIR CONFLICTING STANDARDS OF REVIEW IN THE CONTEXT OF CONFLICTED ADMINISTRATORS OR FIDUCIARIES.

In *Firestone*, this Court used analogy to the law of trusts to establish the standard of review applicable to actions for denial benefits brought pursuant to ERISA § 502(a)(1)(B), 29 U.S.C.

§ 1132(a)(1)(B). Recognizing that ERISA "abounds with the language and terminology of trust law," 489 U.S. at 110, this Court held that where the plan confers discretion upon a plan administrator or fiduciary, federal courts should review the claims decision only for an abuse of that discretion. *Id.* at 115.[2] In *Firestone*, the Third Circuit had held that a *de novo* standard of review should apply when the employer itself is the plan administrator because of "the lack of assurance of impartiality on the part of the employer." *Bruch v. Firestone Tire and Rubber Co.*, 828 F.2d 134, 137-145 (3d Cir. 1987). Because this Court rested its decision in *Firestone* upon trust law, and not a "concern for impartiality," the Court only briefly addressed in dictum the impact of a conflict of interest on a deferential standard of review. This Court noted that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an *abuse of discretion*.' " 489 U.S. at 115 (emphasis added) (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)). This Court thus indicated that deference is still owed. In the 17 years since *Firestone* was decided, however, the Court has not provided any further guidance as to the manner in which deference is applied when an alleged conflict of interest exists.

With the dearth of guidance from this Court on this issue, the lower courts have developed conflicting and confusing standards. Federal courts and commentators alike have noted the conflicting approaches of the various circuit courts of appeals. The confusion is such that the circuits do not even agree on what constitutes a conflict, let alone on what standard of review should apply when a conflict is present and which party bears the burden of proof. Some circuits have held that the mere fact that an insurer both funds a plan and makes the

2. This is consistent with the general principle of trust law that where a trust confers discretionary authority upon a trustee, courts will not interfere with the trustee's exercise of that discretion absent indication that the trustee has abused that discretion. Restatement (Second) of Trusts § 187 cmt. d (1959).

benefits decisions under it constitutes an inherent conflict of interest. *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1326 (11th Cir. 2001). Others find that this is insufficient to establish an inherent conflict of interest. *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 (1st Cir. 2005) (mere fact that plan administrator pays claims out of its own assets does not deprive the administrator of discretion granted by the plan); *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 409 (7th Cir. 2004) (most insurers are so well diversified that the decision in any one case has no perceptible effect on the bottom line; unless an insurer or administrator pays its staff more for denying claims than granting them, the people actually implementing benefit systems are impartial); *Perlman v. Swiss Bank Corp.*, 195 F.3d 975, 981 (7th Cir. 1999) (fact that plan insurer was also administrator did not amount to a conflict of interest because "[w]hen the administrator is a large corporation, the firm has a financial interest, but the award in any one case will have only a trivial effect on its operating results"). Still others find that this circumstance either may or may not amount to a conflict of interest. *Davolt v. Executive Comm. of O'Reilly Auto.*, 206 F.3d 806, 809 (8th Cir. 2000) (fact that the plan administrator is also the insurer may give rise to a conflict of interest, but assumption that such conflict exists is inappropriate).

As for the standard of review to be applied, the decisions of the various circuit courts of appeals defy easy classification. The Ninth Circuit holds that the mere existence of a conflict of interest is insufficient to alter the standard of review. In *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995), the Ninth Circuit held that the deferential "arbitrary and capricious" or "abuse of discretion" standard of review applies unless the claimant presents "material, probative evidence, *beyond the mere fact of the apparent conflict*, tending to show the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Id.* (emphasis added). If the claimant presents such evidence, however, the benefit

determination is presumptively void, although the administrator may rebut this presumption by producing evidence sufficient to establish that the same decision would have been made even absent the taint. If the plan fails to carry this burden, the decision is reviewed *de novo*. *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 829 (9th Cir. 2002), *rev'd on other grounds*, 538 U.S. 822 (2003).

The Second, Sixth and Seventh Circuits also essentially hold that the mere existence of a conflict of interest does not justify applying a less deferential standard of review unless there is evidence that the conflict in fact affected or tainted the benefit decision. *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (claimant required to produce evidence that "the administrator was *in fact* influenced by" the alleged conflict of interest) (emphasis added);[3] *Peruzzi v. Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998) (rejecting claimant's argument that a "less deferential" standard of review should apply where claimant failed to present evidence sufficient to establish that administrator was motivated by self-interest); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998) (claimant must provide "specific evidence of actual bias" showing that there is "a significant conflict" before court will apply a less deferential standard of review).

The Eleventh Circuit essentially holds that claim determinations of a conflicted administrator or fiduciary automatically are subject to a less deferential standard of review, irrespective of whether there is any evidence that the conflict actually affected the benefit decision. *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990) (where claimant demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits

3. If the claimant presents sufficient evidence that the conflict of interest affected the decision, the Second Circuit reviews the benefit determination *de novo*. *Sullivan*, 82 F.3d at 1255-56.

determinations, the burden shifts to the fiduciary to prove that its decision was not tainted by self-interest). Under the Eleventh Circuit's approach, the court first assesses whether the benefit determination is "wrong" from the perspective of a *de novo* review. *Levinson*, 245 F.3d at 1326. If so, the determination is considered arbitrary and capricious unless the conflicted administrator or fiduciary justifies the determination on the grounds of its benefit to the class of all plan participants and beneficiaries. *Id.*; *Brown*, 898 F.2d at 1566-67.

The Third, Fourth, Fifth and Tenth Circuits employ a "sliding scale" of deference, under which the reviewing court always applies the abuse of discretion standard, but the degree of deference varies inversely with the evidence establishing a conflict of interest. *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 391 (3d Cir. 2000) (adopting a sliding scale approach); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993) (deference shown to the benefit decision "will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict"); *Vega v. National Life Ins. Servs. Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*) ("[t]he greater the evidence of a conflict on the part of the administrator, the less deferential [the] abuse of discretion standard will be"); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826 (10th Cir. 1996) (adopting a sliding scale approach).

As the Tenth Circuit recently observed, the Circuits that have adopted the sliding scale approach provide no guidance as to "how much less" deference the reviewing court should afford the conflicted administrator. *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1004 (10th Cir. 2004), *cert. denied*, 125 S.Ct. 1972 (2005). Under the Tenth Circuit's version of the sliding scale approach, the court shifts the burden of proof to the conflicted administrator or fiduciary, who must establish that its decision was reasonable under the traditional arbitrary and capricious standard. Where a sufficiently severe conflict

of interest exists, the court shows less deference to the administrator. *Id.* at 1183.

Although the Eighth Circuit previously indicated that it subscribed to the Eleventh Circuit's approach in *Brown*, *see Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997) (holding that the "perpetual conflict" which exists when an insurer administers benefits from its own plan warrants a *de novo* standard of review), it now appears to have settled upon the sliding scale approach, albeit a modified version. *Phillips-Foster v. UNUM Life Ins. Co. of Am.*, 302 F.3d 785, 795 (8th Cir. 2002) (following the sliding scale approach); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161-62 (8th Cir. 1998) (explicitly adopting the sliding scale approach). Under the Eighth Circuit's variation, a sliding scale of deference is applied only if the claimant presents "material probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to [the claimant]." *Woo*, 144 F.3d at 1160, *quoted in Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 587-88 (8th Cir. 1999).

The First Circuit applies another test, assessing the "reasonableness" of the benefit determination in light of the context in which the decision was made. *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999).

The Ninth Circuit's decision below exemplifies further the confusion surrounding the applicable standard of review. In a very brief, unpublished opinion, the Ninth Circuit held that, notwithstanding the plan's grant of discretion, a *de novo* standard of review should apply based solely on the fact that in earlier proceedings, MetLife initially had determined that respondent was ineligible for benefits, but subsequently reversed itself. MetLife's decision to resolve its prior dispute with respondent by awarding benefits is not probative of whether a purported "conflict of interest" influenced its separate and distinct determination in calculating the benefits owing. The Ninth

Circuit's decision creates a perverse incentive for plans to never alter their determinations, despite ERISA's contrary purpose of mandating that, upon request of the beneficiary, plans fully and fairly review all benefit decisions without deference to the initial determination, altering the determination if warranted by the review.

B. THE CONFLICT AMONG THE CIRCUITS UNDERMINES BASIC ERISA POLICIES AND ADVERSELY AFFECTS EMPLOYEE BENEFIT PLANS.

1. The Standard of Review Issue Affects A Large Proportion of ERISA Litigation

It is important for the efficient operation of employer-sponsored benefit plans covered by ERISA that this Court resolve the conflict among the circuits on the standard of review. Given the large number of plans that are either insured or both self-funded and self-administered, the question of the standard of review applicable to benefit determinations rendered by allegedly conflicted administrators and/or fiduciaries frequently arises. As this Court noted in *Firestone*, the decision regarding the standard of review can be determinative of the outcome of the action. 489 U.S. at 115.

It also is important that the Court resolve this conflict because of the broad scope of ERISA actions it affects. ERISA applies to a variety of employer-sponsored benefit plans, the most common of which are health benefit plans, disability income insurance plans, life insurance plans and pension plans. Disputes over the standard of review can affect virtually every aspect of a wide range of benefit decisions. A few examples are:

1) in the context of a health benefits plan, whether a particular medical treatment is medically necessary,[4] experimental or otherwise not

4. *Doe v. Travelers Ins. Co.*, 167 F.3d at 58-59.

covered by the plan;[5] and whether a particular condition qualifies as a preexisting condition;[6]

2) in the context of disability income insurance plans, whether the claimant is disabled as defined by the plan,[7] and whether any plan limitations on benefits are applicable to the claims (*e.g.*, limitations on mental or psychiatric illnesses);[8]

3) in the context of life insurance plans, whether the insured's death was accidental;[9] and

4) in the context of pension plans, years of service credit and the level of pension benefits.[10]

The issue even arises in the context of the plan's determination whether a particular individual is an employee or beneficiary covered by the plan. *See Vega*, 188 F.3d 287.

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5. *Peruzzi*, 137 F.3d at 433-35.

6. *Davolt*, 206 F.3d at 809; *Chambers*, 100 F.3d at 818.

7. *Alford v. DCH Foundation Group Long Term Disability Plan*, 311 F.3d 955, 960 (9th Cir. 2002); *Levinson*, 245 F.3d at 1325-27; *Pinto*, 214 F.3d at 379.

8. *Cochran v. Trans-General Life Ins. Co.*, 12 Fed.Appx. 277, 2001 WL 392050 (6th Cir. Apr. 13, 2001); *Lang v. Long Term Disability Plan of Sponsor Applied Remote Tech. Inc.*, 125 F.3d 794, 799 (9th Cir. 1997).

9. *Mers*, 144 F.3d at 1024; *Hung v. Guardian Life Ins. Co. of Am.*, 28 Fed.Appx. 268, 2002 WL 104234 (4th Cir. Jan. 28, 2002).

10. *Johannsen v. District No. 1— Pacific Coast Dist, MEBA Pension Plan*, 292 F.3d 159 (4th Cir. 2002).

2. The Conflict Undermines the National Uniform Regulation Intended by ERISA, and Consequently Increases the Cost to Employers of Providing Benefit Plans.

Conflicting interpretations of federal law are disfavored generally and they are particularly problematic in the ERISA context. The ongoing conflict and confusion with respect to the standard of review applicable to benefit decisions of conflicted administrators and fiduciaries undermines the public policies underlying ERISA. In enacting ERISA, Congress was mindful not only of the need to establish certain minimum standards to protect the rights of employees, but also of the fact that benefit plans are voluntary on the part of employers. H.R. Rep. No. 93-533, at 9 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4647. One of ERISA's bedrock purposes therefore is to encourage the formation of employee benefit plans. 29 U.S.C. § 1001b(c)(2). Congress accordingly sought to minimize disincentives to the establishment of such plans and to facilitate their establishment at a reasonable cost.

The basic thrust of ERISA is to avoid multiplicity of regulation in order to permit uniform national administration of employee benefit plans. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995). For over 30 years, ERISA's uniform regulation of employee benefit plans has fostered and protected the development of a system that extends crucial employee benefits to a vast swath of the nation's working population. ERISA has encouraged employers to take on the challenge of sponsoring benefit plans to provide employees and other beneficiaries with substantial financial protection from the high cost of health care, from the financial risk of a disabling illness or injury, and for financial security in retirement. A key component of ERISA's success in expanding and enhancing employee benefits is the protection it affords plan sponsors, which frequently have employees and operations in many states, from the burdens of

having to comply with multiple regulatory regimes. As this Court has noted, conflicting requirements make benefit administration more difficult and inefficient. When inefficiencies or difficulties are introduced into the benefit administration system, employers may decide to reduce the level of benefits offered, or to cease offering the benefits entirely. *Fort Halifax Packing Co.*, 482 U.S. at 11.

The disruption to a uniform system of administration is no less problematic when the lack of uniformity stems from conflicting interpretations of federal law, than when it results from conflicting state laws and regulatory requirements. In either context, unless the most stringent of the conflicting requirements is adhered to, claims procedures must be tailored to the particular jurisdiction in which the claim arises. Both situations increase the cost of providing benefits for all participants.

Moreover, due to the conflict on this issue, there is no clear guidance as to how claims processing should be structured so that plans can successfully retain a traditional degree of discretion in making claims decisions. Indeed, approaches adopted by certain circuits in practice essentially result in a *de novo* standard of review.

3. The Circuit Conflict Undermines ERISA's Civil Enforcement Scheme, Increasing Litigation and Consequently Further Increasing the Cost to Employers of Providing Benefit Plans.

Another essential part of ERISA's statutory scheme is its "carefully integrated" civil enforcement scheme, which this Court has described as "one of the essential tools for accomplishing the stated purposes of ERISA." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990), *citing Pilot Life Ins. Co. v Dedeaux*, 481 U.S. 41, 52, 54 (1987). The primary goal of this scheme is "to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and

expeditiously." *Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1472 (9th Cir. 1993). Under an abuse of discretion standard of review, the admissible evidence is limited to the administrative record, which consists of the insurance policy or plan document and claim file. Costly discovery of additional evidence (e.g., document requests, depositions, expert witness fees and reports) is either prohibited, unnecessary or severely limited. Because admissible evidence is typically limited to documents contained in the administrative record, ERISA lawsuits can be resolved promptly through dispositive motions by allowing the reviewing court to focus on the issue of whether the claim determination was reasonable and supported by substantial evidence. ERISA litigation typically is resolved quickly and without the opportunity for attorneys from both sides to generate enormous amounts of discovery and to engage in costly and unnecessary activity. This relatively inexpensive method of litigation inures to the benefit of all plan participants by helping to maintain the costs for providing employee benefits at a reasonable level.

The current conflict and confusion among the circuit courts of appeals regarding the standard of review applicable to decisions of conflicted administrators and fiduciaries undermine this purpose by rendering ERISA's enforcement mechanism more costly in terms of both time and financial resources. Because of the ongoing uncertainty on this issue, the applicable standard of review for a conflicted decision maker is frequently litigated in ERISA actions, causing the parties to spend additional time and money in litigation. The uncertainty also generates additional litigation because the parties are less able to assess how the benefit determination will be viewed by reviewing courts.

4. The Conflict Negatively Impacts Benefit Plans and Employers in Additional Ways.

The conflict and confusion surrounding the applicable standard of review has additional significant negative ramifications for benefit plans, whether insured or self-funded.

The conflict creates an incentive for employers who desire a traditional degree of deference in their benefit plans to leave the insurance market or simply not offer the benefit plan. There essentially are three basic options in structuring a benefit plan: 1) insure the plan; 2) self-fund and self-administer the plan; or 3) self-fund the plan but hire an independent third party administrator to administer benefit claims. Under the current patchwork of federal decisions, the only fail-safe means of preserving a traditional degree of deference appears to be the third option — structuring the plan so that separate entities fund and administer the plan. Although self-funding and retaining a third party administrator may be an option for large employers, medium-sized and smaller employers rarely have the necessary financial resources, infrastructure or desire to self-fund a benefit plan. Medium and smaller employers with no practical alternative to funding a benefit plan through the purchase of insurance may end up bearing not only the increased cost resulting from an uncertain standard of review, but also increased costs stemming from a flight of larger employers from the insurance market. As a result, medium and smaller employers in particular may choose either to offer a reduced level of benefits, or not to offer benefit plans at all.[11]

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11. In fact, only about one fourth of workers employed by small employers have disability benefits. *See National Compensation Survey: Employee Benefits in Private Industry in the United States*, March 2005, U.S. Department of Labor, Bureau of Labor Statistics, August 2005, *available at* http://www.bls.gov/ncs/ebs/sp/ebsm0003.pdf. At private establishments with less than 100 workers, 28 percent of workers are covered by a short-term disability plan and 19 percent are covered by a long-term disability plan. *Id.* at 8 (Table 4). In a 2002 ACLI survey, small employers who did not offer disability coverage to their workers cited cost as the primary reason for not offering coverage. *See Disability Income Insurance: Penetrating the Small-Employer Market*, ACLI, 2002, *available at* http://www.acli.org/ACLI/About+ACLI+nonmember/Industry+Facts/DI+Insurance+Small-Employer+Market+Survey.htm. Sixty-seven percent of small employers without disability coverage classify "coverage is too expensive" as a major reason they do not offer it; an additional 10 percent report this is a minor reason. *Id.* at 8.

C. A TRADITIONAL DEFERENTIAL STANDARD OF REVIEW SHOULD APPLY.

ACLI respectfully submits that benefit determinations rendered by administrators or fiduciaries who are afforded discretion by the terms of the benefit plan but are operating under an alleged conflict of interest should be reviewed under a traditional deferential standard of review in accordance with *Firestone*. Under *Firestone*, a potential conflict of interest is but one of several factors that must be considered in determining whether an abuse of discretion has occurred. It does not, however, modify the standard of review or in any way negate the plan's grant of discretion.

The circuit courts of appeals that have adopted the "presumptively void" and the "sliding scale" approaches essentially determine the standard of review based on who the administrator or fiduciary is. As this Court determined in *Firestone*, the appropriate standard of review under ERISA derives from trust law, and not a concern for impartiality. 489 U.S. at 115. Indeed, ERISA itself permits entities with a conflict of interest to nevertheless act as administrators or fiduciaries. 29 U.S.C. § 1108(c)(3). When the benefit plan grants such entities discretion to make benefit determinations, federal courts should not negate the grant of discretion by altering the standard of review based merely on the potential for a conflict of interest. Moreover, the sliding scale approach creates the danger that that the outcome will be strongly influenced by the sympathetic facts of a particular case.

These approaches also undervalue the role that deference plays in the formation of benefit plans. Upholding a plan's grant of discretionary authority through application of a deferential standard of review provides plan sponsors with a degree of control over the benefit plan and promotes its affordability. As this Court has noted, ERISA does not mandate what, if any,

benefits an employer must provide and employers have large leeway to design their plans. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). Plans therefore have a legitimate interest in retaining discretion to interpret the terms of the plan and to render benefit decisions. Given the enormously wide range of issues that can arise in rendering benefit decisions under any plan, it is not possible to predict every type of issue and claim that may arise. Moreover, all plans have some terms that are arguably ambiguous as applied to peculiar facts. Discretion and a deferential standard of review enable the plan to resolve such issues in a manner that best protects the interests of all participants in the plan.

Application of a deferential standard of review also provides adequate protection for the interests of the claimants under benefit plans. As Judge Easterbrook recently wrote for the Seventh Circuit, an employer

> has no reason to deceive its employees about the quality of fringe benefits on offer; that would just besmirch its reputation and make it harder to hire good people in competition with other [employers]. One might as well say that because a health maintenance organization has an incentive to skimp on care (for it does not collect extra fees for additional medical services), the judiciary must intervene to force HMOs to offer more or better care than they have promised by contract. Yet the Supreme Court held in *Pegram v. Herdrich*, 530 U.S. 211, 147 L. Ed. 2d 164, 120 S. Ct. 2143 (2000), that HMOs' well-known incentive to shave the costs of care does not justify "correction" under the banner of ERISA. The choice between fee-for-service and HMO-style incentives, neither of them perfect, is left to employers who must compete for good

> workers using a combination of salary and fringe benefits.

Leipzig, 362 F.3d at 408-409. Similarly with respect to benefit claims decisions by insurers under insured plans, the Seventh Circuit previously explained that:

> [I]t is a poor business decision [for an insurer] to resist paying meritorious claims for benefits. Companies . . . that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans. . . . [These employers] want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers.

Mers, 144 F.3d at 1021.

Industry statistics regarding claims denials also provide strong evidence to dispute the myth that insurers are motivated to deny valid claims, and buttress the foregoing analysis of the Seventh Circuit. A 2002 claims survey conducted by the Health Insurers Association of America ("HIAA") of its members' claims experience revealed that on average 14% of health benefit claims were denied. Significantly, 48% of all claims denials were due to the submission of a duplicate claim, 22% were denied because the policy had lapsed and 20% were denied because the individual was no longer covered under the policy. HIAA, "Results from an HIAA Survey on Claims Payment Processes," at 10 (March 2003), *available at* http://www.ahipresearch.org/PDFs/21_ClaimsPaymentProcessesSurvey

Chartbook.pdf. The remaining 10% of denied claims represents only 1.4% of the total claims reported.[12]

As these statistics amply demonstrate, the overwhelming majority of benefit claims are paid by insurers. In sum, the assumption implicitly underlying the "presumptively void" and "sliding scale" approaches – that self-interested administrators and fiduciaries are motivated to deny valid claims – is not correct.

D. THE NINTH CIRCUIT'S INCLUSION OF STOCK OPTION PROFITS IN "BASIC MONTHLY EARNINGS" FOR PURPOSES OF CALCULATING PLAN BENEFITS RAISES SIGNIFICANT PUBLIC POLICY CONCERNS.

The Ninth Circuit's decision raises significant public policy concerns for the funding and underwriting of benefit plans, especially for disability income plans. The intended purpose of long term disability plans is to replace a portion of beneficiaries' normal earnings stream in the event of a qualifying disability (approximately 60% less offsets for certain other income to which the beneficiary may be entitled, such as Social Security Disability Income benefits). This benefit level makes disability plans more affordable for employers and also preserves motivation for employees who suffer a disabling condition to pursue rehabilitation and/or retraining for other suitable employment. The Ninth Circuit's decision can result in beneficiaries receiving windfall benefits far in excess of their normal earnings stream, particularly where beneficiaries refrain from exercising stock options or selling the stock until shortly before the qualifying event, *i.e.*, the onset of a disabling condition. In the case at hand, the inclusion of profits from respondent's exercise of accumulated stock options resulted in her base annual income for calculating benefits increasing to $151,855 from $28,850. (Pet. at 5.) This more than five-fold

12. The ACLI is not aware of any studies that compile statistics on the denial of long term disability claims.

increase results in respondent's annual disability benefits dwarfing her normal, pre-disability income.[13] As a result, the public policies underlying the plan's benefit level are severely undermined.

The Ninth Circuit's decision also raises significant issues in funding and underwriting such plans, given the vagaries in stock market valuation and beneficiaries' unpredictable actions and timing in exercising stock options or selling the stock. Premiums for insured disability plans are determined based on the number of covered employees, the payroll earnings reported by the employer for the covered employees, and actuarial data regarding the likely incidence of qualifying disability for the group. Because income cannot be realized from stock options until they are exercised by the employee, the earnings reported by employers for purposes of calculating policy premiums typically do not include the potential income that may be realized upon the exercise of those options or sale of stock. Indeed, the inclusion of such potential income in the employer's reporting of employee earnings raises numerous practical issues given the multitude of uncertainties surrounding the realization of any income from stock options. Chief among these uncertainties are the vagaries of the stock market and the fluctuating value of the underlying stock. Under certain circumstances, stock options may not even be exercised if they will result in little or no realized income.

The fact that the employee, and not the employer, makes the ultimate decision as to whether and when to exercise the stock options also is a significant complication. The employer merely sets the price at which the employee can purchase the number of shares covered by the stock option. The income, if any, ultimately realized through exercise of the stock options depends upon the employee's timing in exercising the options

13. Per respondent's calculations, the monthly benefit due her under the plan is $7,592.75, exclusive of offsets for other income. (Respondent's App. Br. at 4.) Her annual benefit therefore would be $91,113.

and decisions regarding whether to hold or sell the stock.[14] As a result, the premiums charged for the policies funding long term disability plans typically do not encompass the windfall income that can result from the exercise of stock options. Including such windfall income in calculating plan benefits imposes liability for which no corresponding premium was collected.

CONCLUSION

ACLI respectfully requests that the Court grant Metropolitan Life Insurance Company's petition for a writ of certiorari.

Respectfully submitted,

CARL B. WILKERSON
Vice President & Chief Counsel, Securities & Litigation
LISA TATE
Senior Counsel, Litigation
AMERICAN COUNCIL OF LIFE INSURERS
101 Constitution Ave., N.W.
Suite 700
Washington, D.C. 20001-2133
(202) 624-2153

RICHARD B. LAZARUS
Counsel of Record
CAROLYN DOPPELT GRAY
TERESA L. JAKUBOWSKI
BARNES & THORNBURG LLP
750 17th Street, N.W.
Washington, D.C. 20006
(202) 289-1313

Counsel for Amicus Curiae

14. The fact that the employee controls the exercise of the stock option also can lead to unintended wide disparities among similarly-situated employees as to the amount of disability benefits ultimately received. The additional annualized income realized from the exercise of stock options may be significantly less for employees who frequently exercise vested stock options in order to average the associated risk, as opposed to those employees who accumulate options and exercise them all at once. Although the employer has conveyed the right to purchase the stock at a set rate, employees use and exercise those rights in different ways. For this reason, stock options are more analogous to fringe benefits, than to salary or wages.